

THIS REPORT IS REQUIRED BY LAW (42 USC 1395g; 42 CFR 413.20(b)).
FAILURE TO REPORT CAN RESULT IN ALL INTERIM PAYMENTS MADE SINCE
THE BEGINNING OF THE COST REPORT PERIOD BEING DEEMED OVERPAYMENTS
(42 USC 1395g).

WORKSHEET S
PARTS I & II

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX	I	PROVIDER NO:	I PERIOD	I INTERMEDIARY USE ONLY	I DATE RECEIVED:
COST REPORT CERTIFICATION	I	14-1339	I FROM 10/ 1/2009	I --AUDITED --DESK REVIEW	I / /
AND SETTLEMENT SUMMARY	I		I TO 9/30/2010	I --INITIAL --REOPENED	I INTERMEDIARY NO:
			I	I --FINAL 1-MCR CODE	I
				I 00 - # OF REOPENINGS	I

ELECTRONICALLY FILED COST REPORT

DATE: 2/18/2011 TIME 11:24

PART I - CERTIFICATION

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES IDENTIFIED BY THIS REPORT WERE PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OR INDIRECTLY OF A KICKBACK OR WHERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT.

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY THAT I HAVE READ THE ABOVE STATEMENT AND THAT I HAVE EXAMINED THE ACCOMPANYING ELECTRONICALLY FILED OR MANUALLY SUBMITTED COST REPORT AND THE BALANCE SHEET AND STATEMENT OF REVENUE AND EXPENSES PREPARED BY:
TAYLORVILLE MEMORIAL HOSPITAL 14-1339

FOR THE COST REPORTING PERIOD BEGINNING 10/ 1/2009 AND ENDING 9/30/2010 AND THAT TO THE BEST OF MY KNOWLEDGE AND BELIEF, IT IS A TRUE, CORRECT, AND COMPLETE STATEMENT PREPARED FROM THE BOOKS AND RECORDS OF THE PROVIDER IN ACCORDANCE WITH APPLICABLE INSTRUCTIONS, EXCEPT AS NOTED. I FURTHER CERTIFY THAT I AM FAMILIAR WITH THE LAWS AND REGULATIONS REGARDING THE PROVISION OF HEALTH CARE SERVICES, AND THAT THE SERVICES IDENTIFIED IN THIS COST REPORT WERE PROVIDED IN COMPLIANCE WITH SUCH LAWS AND REGULATIONS.

ECR ENCRYPTION INFORMATION
DATE: 2/18/2011 TIME 11:24

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OFFICER OR ADMINISTRATOR OF PROVIDER(S)

TITLE

DATE

PART II - SETTLEMENT SUMMARY

	TITLE V		TITLE XVIII		TITLE XIX
	1	A 2	B 3	4	
1	HOSPITAL	0	533,568	139,530	0
3	SWING BED - SNF	0	54,399	0	0
5	HOSPITAL-BASED SNF	0	0	0	0
100	TOTAL	0	587,967	139,530	0

THE ABOVE AMOUNTS REPRESENT "DUE TO" OR "DUE FROM" THE APPLICABLE PROGRAM FOR THE ELEMENT OF THE ABOVE COMPLEX INDICATED

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0050. The time required to complete this information collection is estimated 662 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: Centers for Medicare & Medicaid Services, 7500 Security Boulevard, N2-14-26, Baltimore, MD 21244-1850, and to the Office of the Information and Regulatory Affairs, Office of Management and Budget, Washington, D.C. 20503.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX ADDRESS

1 STREET: 201 EAST PLEASANT STREET	P.O. BOX:	
1.01 CITY: TAYLORVILLE	STATE: IL	ZIP CODE: 62568- COUNTY: CHRISTIAN

HOSPITAL AND HOSPITAL-BASED COMPONENT IDENTIFICATION;

COMPONENT 0	COMPONENT NAME 1	PROVIDER NO. 2	NPI NUMBER 2.01	DATE CERTIFIED 3	PAYMENT SYSTEM (P,T,O OR N)		
					V	XVIII	XIX
02.00 HOSPITAL	TAYLORVILLE MEMORIAL HOSPITAL	14-1339		9/ 1/2004	4	5	6
04.00 SWING BED - SNF	TAYLORVILLE MEMORIAL -SWB	14-2339		9/ 1/2004	N	O	N
06.00 HOSPITAL-BASED SNF	TAYLORVILLE SKILLED NURSING FACILITY	14-5539		7/ 1/1966	N	P	N

17 COST REPORTING PERIOD (MM/DD/YYYY) FROM: 10/ 1/2009 TO: 9/30/2010

18 TYPE OF CONTROL

1	2
2	

TYPE OF HOSPITAL/SUBPROVIDER

19 HOSPITAL 1

20 SUBPROVIDER

OTHER INFORMATION

21 INDICATE IF YOUR HOSPITAL IS EITHER (1)URBAN OR (2)RURAL AT THE END OF THE COST REPORT PERIOD IN COLUMN 1. IF YOUR HOSPITAL IS GEOGRAPHICALLY CLASSIFIED OR LOCATED IN A RURAL AREA, IS YOUR BED SIZE IN ACCORDANCE WITH CFR 42 412.105 LESS THAN OR EQUAL TO 100 BEDS, ENTER IN COLUMN 2 "Y" FOR YES OR "N" FOR NO.

21.01 DOES YOUR FACILITY QUALIFY AND IS CURRENTLY RECEIVING PAYMENT FOR DISPROPORTIONATE SHARE HOSPITAL ADJUSTMENT IN ACCORDANCE WITH 42 CFR 412.106? ENTER IN COLUMN 1 "Y" FOR YES OR "N" FOR NO. IS THIS FACILITY SUBJECT TO THE PROVISIONS OF 42 CFR 412.106(c)(2) (PICKLE AMENDMENT HOSPITALS)? ENTER IN COLUMN 2 "Y" FOR YES OR "N" FOR NO. N

21.02 HAS YOUR FACILITY RECEIVED A NEW GEOGRAPHIC RECLASSIFICATION STATUS CHANGE AFTER THE FIRST DAY OF THE COST REPORTING PERIOD FROM RURAL TO URBAN AND VICE VERSA? ENTER "Y" FOR YES AND "N" FOR NO. IF YES, ENTER IN COLUMN 2 THE EFFECTIVE DATE (MM/DD/YYYY) (SEE INSTRUCTIONS).

21.03 ENTER IN COLUMN 1 YOUR GEOGRAPHIC LOCATION EITHER (1)URBAN OR (2)RURAL. IF YOU ANSWERED URBAN IN COLUMN 1 INDICATE IF YOU RECEIVED EITHER A WAGE OR STANDARD GEOGRAPHICAL RECLASSIFICATION TO A RURAL LOCATION, ENTER IN COLUMN 2 "Y" FOR YES AND "N" FOR NO. IF COLUMN 2 IS YES, ENTER IN COLUMN 3 THE EFFECTIVE DATE (MM/DD/YYYY)(SEE INSTRUCTIONS) DOES YOUR FACILITY CONTAIN 100 OR FEWER BEDS IN ACCORDANCE WITH 42 CFR 412.105? ENTER IN COLUMN 4 "Y" OR "N". ENTER IN COLUMN 5 THE PROVIDERS ACTUAL MSA OR CBSA. 2 Y

21.04 FOR STANDARD GEOGRAPHIC CLASSIFICATION (NOT WAGE), WHAT IS YOUR STATUS AT THE BEGINNING OF THE COST REPORTING PERIOD. ENTER (1)URBAN OR (2)RURAL 2

21.05 FOR STANDARD GEOGRAPHIC CLASSIFICATION (NOT WAGE), WHAT IS YOUR STATUS AT THE END OF THE COST REPORTING PERIOD. ENTER (1)URBAN OR (2)RURAL 2

21.06 DOES THIS HOSPITAL QUALIFY FOR THE 3-YEAR TRANSITION OF HOLD HARMLESS PAYMENTS FOR SMALL RURAL HOSPITAL; UNDER THE PROSPECTIVE PAYMENT SYSTEM FOR HOSPITAL OUTPATIENT SERVICES UNDER DRA §5105 OR MIPPA §147? (SEE INSTRUCT) ENTER "Y" FOR YES, AND "N" FOR NO. N

21.07 DOES THIS HOSPITAL QUALIFY AS A SCH WITH 100 OR FEWER BEDS UNDER MIPPA §147? ENTER "Y" FOR YES AND "N" FOR NO. (SEE INSTRUCTIONS). IS THIS A SCH OR EACH THAT QUALIFIES FOR THE OUTPATIENT HOLD HARMLESS PROVISION IN ACA SECTION 3121? ENTER IN COLUMN 2 "Y" FOR YES OR "N" FOR NO. (SEE INSTRUCTIONS) N N

21.08 WHICH METHOD IS USED TO DETERMINE MEDICAID DAYS ON S-3, PART I, COL. 5 ENTER IN COLUMN 1, "1" IF IT IS BASED ON DATE OF ADMISSION, "2" IF IT IS BASED ON CENSUS DAYS, OR "3" IF IT IS BASED ON DATE OF DISCHARGE. IS THIS METHOD DIFFERENT THAN THE METHOD USED IN THE PRECEEDING COST REPORTING PERIOD? ENTER IN COLUMN 2, "Y" FOR YES OR "N" FOR NO. N

22 ARE YOU CLASSIFIED AS A REFERRAL CENTER? N

23 DOES THIS FACILITY OPERATE A TRANSPLANT CENTER? IF YES, ENTER CERTIFICATION DATE(S) BELOW. N

23.01 IF THIS IS A MEDICARE CERTIFIED KIDNEY TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION DATE IN COL. 3. / / / /

23.02 IF THIS IS A MEDICARE CERTIFIED HEART TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION DATE IN COL. 3. / / / /

23.03 IF THIS IS A MEDICARE CERTIFIED LIVER TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION DATE IN COL. 3. / / / /

23.04 IF THIS IS A MEDICARE CERTIFIED LUNG TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION DATE IN COL. 3. / / / /

23.05 IF MEDICARE PANCREAS TRANSPLANTS ARE PERFORMED SEE INSTRUCTIONS FOR ENTERING CERTIFICATION AND TERMINATION DATE. / / / /

23.06 IF THIS IS A MEDICARE CERTIFIED INTESTINAL TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION DATE IN COL. 3. / / / /

23.07 IF THIS IS A MEDICARE CERTIFIED ISLET TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION DATE IN COL. 3. / / / /

24 IF THIS IS AN ORGAN PROCUREMENT ORGANIZATION (OPO), ENTER THE OPO NUMBER IN COLUMN 2 AND TERMINATION DATE IN COLUMN 3 (MM/DD/YYYY) / /

24.01 IF THIS IS A MEDICARE TRANSPLANT CENTER; ENTER THE CCN (PROVIDER NUMBER) IN COLUMN 2, THE CERTIFICATION DATE OR RECERTIFICATION DATE (AFTER 12/26/2007) IN COLUMN 3 (mm/dd/yyyy). / /

25	IS THIS A TEACHING HOSPITAL OR AFFILIATED WITH A TEACHING HOSPITAL AND YOU ARE RECEIVING PAYMENTS FOR I&R?	N
25.01	IS THIS TEACHING PROGRAM APPROVED IN ACCORDANCE WITH CMS PUB. 15-I, CHAPTER 4?	N
25.02	IF LINE 25.01 IS YES, WAS MEDICARE PARTICIPATION AND APPROVED TEACHING PROGRAM STATUS IN EFFECT DURING THE FIRST MONTH OF THE COST REPORTING PERIOD? IF YES, COMPLETE WORKSHEET E-3, PART IV. IF NO, COMPLETE WORKSHEET D-2, PART II.	
25.03	AS A TEACHING HOSPITAL, DID YOU ELECT COST REIMBURSEMENT FOR PHYSICIANS' SERVICES AS DEFINED IN CMS PUB. 15-I, SECTION 2148? IF YES, COMPLETE WORKSHEET D-9.	N
25.04	ARE YOU CLAIMING COSTS ON LINE 70 OF WORKSHEET A? IF YES, COMPLETE WORKSHEET D-2, PART I.	N
25.05	HAS YOUR FACILITY DIRECT GME FTE CAP (COLUMN 1) OR IME FTE CAP (COLUMN 2) BEEN REDUCED UNDER 42 CFR 413.79(c)(3) OR 42 CFR 412.105(f)(1)(iv)(B)? ENTER "Y" FOR YES AND "N" FOR NO IN THE APPLICABLE COLUMNS. (SEE INSTRUCTIONS)	
25.06	HAS YOUR FACILITY RECEIVED ADDITIONAL DIRECT GME FTE RESIDENT CAP SLOTS OR IME FTE RESIDENTS CAP SLOTS UNDER 42 CFR 413.79(c)(4) OR 42 CFR 412.105(f)(1)(iv)(C)? ENTER "Y" FOR YES AND "N" FOR NO IN THE APPLICABLE COLUMNS (SEE INSTRUCTIONS)	
26	IF THIS IS A SOLE COMMUNITY HOSPITAL (SCH), ENTER THE NUMBER OF PERIODS SCH STATUS IN EFFECT IN THE C/R PERIOD. ENTER BEGINNING AND ENDING DATES OF SCH STATUS ON LINE 26.01. SUBSCRIPT LINE 26.01 FOR NUMBER OF PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES.	0
26.01	ENTER THE APPLICABLE SCH DATES: BEGINNING: / / ENDING: / /	/ /
26.02	ENTER THE APPLICABLE SCH DATES: BEGINNING: / / ENDING: / /	/ /
27	DOES THIS HOSPITAL HAVE AN AGREEMENT UNDER EITHER SECTION 1883 OR SECTION 1913 FOR SWING BEDS. IF YES, ENTER THE AGREEMENT DATE (MM/DD/YYYY) IN COLUMN 2.	Y 9/ 1/2004
28	IF THIS FACILITY CONTAINS A HOSPITAL-BASED SNF, ARE ALL PATIENTS UNDER MANAGED CARE OR THERE WERE NO MEDICARE UTILIZATION ENTER "Y", IF "N" COMPLETE LINES 28.01 AND 28.02	N
28.01	IF HOSPITAL BASED SNF, ENTER APPROPRIATE TRANSITION PERIOD 1, 2, 3, OR 100 IN COLUMN 1. ENTER IN COLUMNS 2 AND 3 THE WAGE INDEX ADJUSTMENT FACTOR BEFORE AND ON OR AFTER THE OCTOBER 1ST (SEE INSTRUCTIONS)	1 2 3 4 ----- 100 0.0000 0.8312
28.02	ENTER IN COLUMN 1 THE HOSPITAL BASED SNF FACILITY SPECIFIC RATE(FROM YOUR FISCAL INTERMEDIARY) IF YOU HAVE NOT TRANSITIONED TO 100% PPS SNF PPS PAYMENT. IN COLUMN 2 ENTER THE FACILITY CLASSIFICATION URBAN(1) OR RURAL (2). IN COLUMN 3 ENTER THE SNF MSA CODE OR TWO CHARACTER STATE CODE IF A RURAL BASED FACILITY. IN COLUMN 4, ENTER THE SNF CBSA CODE OR TWO CHARACTER CODE IF RURAL BASED FACILITY	0.00 2 14 99914
A NOTICE PUBLISHED IN THE "FEDERAL REGISTER" VOL. 68, NO. 149 AUGUST 4, 2003 PROVIDED FOR AN INCREASE IN THE RUG PAYMENTS BEGINNING 10/01/2003. CONGRESS EXPECTED THIS INCREASE TO BE USED FOR DIRECT PATIENT CARE AND RELATED EXPENSES. ENTER IN COLUMN 1 THE PERCENTAGE OF TOTAL EXPENSES FOR EACH CATEGORY TO TOTAL SNF REVENUE FROM WORKSHEET G-2, PART I, LINE 6, COLUMN 3. INDICATE IN COLUMN 2 "Y" FOR YES OR "N" FOR NO IF THE SPENDING REFLECTS INCREASES ASSOCIATED WITH DIRECT PATIENT CARE AND RELATED EXPENSES FOR EACH CATEGORY. (SEE INSTR)		
28.03	STAFFING	% Y/N 25.89% Y
28.04	RECRUITMENT	0.00%
28.05	RETENTION	0.00%
28.06	TRAINING	0.07% Y
28.07	THERAPY SERVICES	12.45% Y
28.08	OTHER	0.00%
29	IS THIS A RURAL HOSPITAL WITH A CERTIFIED SNF WHICH HAS FEWER THAN 50 BEDS IN THE AGGREGATE FOR BOTH COMPONENTS, USING THE SWING BED OPTIONAL METHOD OF REIMBURSEMENT?	N
30	DOES THIS HOSPITAL QUALIFY AS A RURAL PRIMARY CARE HOSPITAL (RPCH)/CRITICAL ACCESS HOSPITAL(CAH)? (SEE 42 CFR 485.606ff)	Y
30.01	IF SO, IS THIS THE INITIAL 12 MONTH PERIOD FOR THE FACILITY OPERATED AS AN RPCH/CAH? SEE 42 CFR 413.70	N
30.02	IF THIS FACILITY QUALIFIES AS AN RPCH/CAH, HAS IT ELECTED THE ALL-INCLUSIVE METHOD OF PAYMENT FOR OUTPATIENT SERVICES? (SEE INSTRUCTIONS)	N
30.03	IF THIS FACILITY QUALIFIES AS A CAH, IS IT ELIBILE FOR COST REIMBURSEMENT FOR AMBULANCE SERVICES? IF YES, ENTER IN COLUMN 2 THE DATE OF ELIGIBILITY DETERMINATION (DATE MUST BE ON OR AFTER 12/21/2000).	
30.04	IF THIS FACILITY QUALIFIES AS A CAH, IS IT ELIBILE FOR COST REIMBURSEMENT FOR I&R TRAINING PROGRAMS? ENTER "Y" FOR YES AND "N" FOR NO. IF YES, THE GME ELIMINATION WOULD NOT BE ON WORKSHEET B, PART I, COLUMN 26 AND THE PROGRAM WOULD BE COST REIMBURSED. IF YES COMPLETE WORKSHEET D-2, PART II	N
31	IS THIS A RURAL HOSPITAL QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR 412.113(c).	N
31.01	IS THIS A RURAL SUBPROVIDER 1 QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR 412.113(c).	N
31.02	IS THIS A RURAL SUBPROVIDER 2 QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR 412.113(c).	N
31.03	IS THIS A RURAL SUBPROVIDER 3 QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR 412.113(c).	N
31.04	IS THIS A RURAL SUBPROVIDER 4 QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR 412.113(c).	N
31.05	IS THIS A RURAL SUBPROVIDER 5 QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR 412.113(c).	N
MISCELLANEOUS COST REPORT INFORMATION		
32	IS THIS AN ALL-INCLUSIVE PROVIDER? IF YES, ENTER THE METHOD USED (A, B, OR E ONLY) COL 2.	N
33	IS THIS A NEW HOSPITAL UNDER 42 CFR 412.300 PPS CAPITAL? ENTER "Y" FOR YES AND "N" FOR NO IN COLUMN 1. IF YES, FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2002, DO YOU ELECT TO BE REIMBURSED AT 100% FEDERAL CAPITAL PAYMENT? ENTER "Y" FOR YES AND "N" FOR NO IN COLUMN 2	N
34	IS THIS A NEW HOSPITAL UNDER 42 CFR 413.40 (f)(1)(i) TEFRA?	N
35	HAVE YOU ESTABLISHED A NEW SUBPROVIDER (EXCLUDED UNIT) UNDER 42 CFR 413.40(f)(1)(i)?	N
35.01	HAVE YOU ESTABLISHED A NEW SUBPROVIDER (EXCLUDED UNIT) UNDER 42 CFR 413.40(f)(1)(i)?	N
35.02	HAVE YOU ESTABLISHED A NEW SUBPROVIDER (EXCLUDED UNIT) UNDER 42 CFR 413.40(f)(1)(i)?	
35.03	HAVE YOU ESTABLISHED A NEW SUBPROVIDER (EXCLUDED UNIT) UNDER 42 CFR 413.40(f)(1)(i)?	
35.04	HAVE YOU ESTABLISHED A NEW SUBPROVIDER (EXCLUDED UNIT) UNDER 42 CFR 413.40(f)(1)(i)?	

PROSPECTIVE PAYMENT SYSTEM (PPS)-CAPITAL V XVIII XIX
36 DO YOU ELECT FULLY PROSPECTIVE PAYMENT METHODOLOGY FOR CAPITAL COSTS? (SEE INSTRUCTIONS) 1 2 3
36.01 DOES YOUR FACILITY QUALIFY AND RECEIVE PAYMENT FOR DISPROPORTIONATE SHARE IN ACCORDANCE N N N
WITH 42 CFR 412.320? (SEE INSTRUCTIONS)
37 DO YOU ELECT HOLD HARMLESS PAYMENT METHODOLOGY FOR CAPITAL COSTS? (SEE INSTRUCTIONS) N N N
37.01 IF YOU ARE A HOLD HARMLESS PROVIDER, ARE YOU FILING ON THE BASIS OF 100% OF THE FED RATE? N N N

TITLE XIX INPATIENT SERVICES
38 DO YOU HAVE TITLE XIX INPATIENT HOSPITAL SERVICES? Y
38.01 IS THIS HOSPITAL REIMBURSED FOR TITLE XIX THROUGH THE COST REPORT EITHER IN FULL OR IN PART? N
38.02 DOES THE TITLE XIX PROGRAM REDUCE CAPITAL FOLLOWING THE MEDICARE METHODOLOGY? Y
38.03 ARE TITLE XIX NF PATIENTS OCCUPYING TITLE XVIII SNF BEDS (DUAL CERTIFICATION)? N
38.04 DO YOU OPERATE AN ICF/MR FACILITY FOR PURPOSES OF TITLE XIX? N
40 ARE THERE ANY RELATED ORGANIZATION OR HOME OFFICE COSTS AS DEFINED IN CMS PUB 15-I, CHAP 10? Y 14H058
IF YES, AND THIS FACILITY IS PART OF A CHAIN ORGANIZATION, ENTER IN COLUMN 2 THE CHAIN HOME FI/CONTRACTOR #
OFFICE CHAIN NUMBER. (SEE INSTRUCTIONS).
40.01 NAME: MEMORIAL HEALTH SYSTEM FI/CONTRACTOR NAME
40.02 STREET: 701 NORTH FIRST STREET P.O. BOX:
40.03 CITY: SPRINGFIELD STATE: IL ZIP CODE: 62781-
41 ARE PROVIDER BASED PHYSICIANS' COSTS INCLUDED IN WORKSHEET A? Y
42 ARE PHYSICAL THERAPY SERVICES PROVIDED BY OUTSIDE SUPPLIERS? N
42.01 ARE OCCUPATIONAL THERAPY SERVICES PROVIDED BY OUTSIDE SUPPLIERS? N
42.02 ARE SPEECH PATHOLOGY SERVICES PROVIDED BY OUTSIDE SUPPLIERS? Y
43 ARE RESPIRATORY THERAPY SERVICES PROVIDED BY OUTSIDE SUPPLIERS? N
44 IF YOU ARE CLAIMING COST FOR RENAL SERVICES ON WORKSHEET A, ARE THEY INPATIENT SERVICES ONLY? N
45 HAVE YOU CHANGED YOUR COST ALLOCATION METHODOLOGY FROM THE PREVIOUSLY FILED COST REPORT? N 00/00/0000
SEE CMS PUB. 15-II, SECTION 3617. IF YES, ENTER THE APPROVAL DATE IN COLUMN 2.
45.01 WAS THERE A CHANGE IN THE STATISTICAL BASIS?
45.02 WAS THERE A CHANGE IN THE ORDER OF ALLOCATION?
45.03 WAS THE CHANGE TO THE SIMPLIFIED COST FINDING METHOD?
46 IF YOU ARE PARTICIPATING IN THE NHCMP DEMONSTRATION PROJECT (MUST HAVE A HOSPITAL-BASED SNF) N
DURING THIS COST REPORTING PERIOD, ENTER THE PHASE (SEE INSTRUCTIONS).

IF THIS FACILITY CONTAINS A PROVIDER THAT QUALIFIES FOR AN EXEMPTION FROM THE APPLICATION OF THE LOWER OF COSTS OR CHARGES, ENTER "Y" FOR EACH COMPONENT AND TYPE OF SERVICE THAT QUALIFIES FOR THE EXEMPTION. ENTER "N" IF NOT EXEMPT. (SEE 42 CFR 413.13.)

	PART A	PART B	OUTPATIENT ASC	OUTPATIENT RADIOLOGY	OUTPATIENT DIAGNOSTIC
	1	2	3	4	5
47.00 HOSPITAL	Y	Y	N	N	N
49.00 SNF	N	N			

52 DOES THIS HOSPITAL CLAIM EXPENDITURES FOR EXTRAORDINARY CIRCUMSTANCES IN ACCORDANCE WITH 42 CFR 412.348(e)? (SEE INSTRUCTIONS) N
52.01 IF YOU ARE A FULLY PROSPECTIVE OR HOLD HARMLESS PROVIDER ARE YOU ELIGIBLE FOR THE SPECIAL EXCEPTIONS PAYMENT PURSUANT TO 42 CFR 412.348(g)? IF YES, COMPLETE WORKSHEET L, PART IV N
53 IF YOU ARE A MEDICARE DEPENDENT HOSPITAL (MDH), ENTER THE NUMBER OF PERIODS MDH STATUS IN EFFECT. ENTER BEGINNING AND ENDING DATES OF MDH STATUS ON LINE 53.01. SUBSCRIPT LINE 53.01 FOR NUMBER OF PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES. 0
53.01 MDH PERIOD: BEGINNING: / / ENDING: / /
54 LIST AMOUNTS OF MALPRACTICE PREMIUMS AND PAID LOSSES:
PREMIUMS: 63,161
PAID LOSSES: 0
AND/OR SELF INSURANCE: 107,715
54.01 ARE MALPRACTICE PREMIUMS AND PAID LOSSES REPORTED IN OTHER THAN THE ADMINISTRATIVE AND GENERAL COST CENTER? IF YES, SUBMIT SUPPORTING SCHEDULE LISTING COST CENTERS AND AMOUNTS CONTAINED THEREIN. N
55 DOES YOUR FACILITY QUALIFY FOR ADDITIONAL PROSPECTIVE PAYMENT IN ACCORDANCE WITH 42 CFR 412.107. ENTER "Y" FOR YES AND "N" FOR NO. N

	DATE	Y OR N	LIMIT	Y OR N	FEES
	0	1	2	3	4
56 ARE YOU CLAIMING AMBULANCE COSTS? IF YES, ENTER IN COLUMN 2 THE PAYMENT LIMIT PROVIDED FROM YOUR FISCAL INTERMEDIARY AND THE APPLICABLE DATES FOR THOSE LIMITS IN COLUMN 0. IF THIS IS THE FIRST YEAR OF OPERATION NO ENTRY IS REQUIRED IN COLUMN 2. IF COLUMN 1 IS Y, ENTER Y OR N IN COLUMN 3 WHETHER THIS IS YOUR FIRST YEAR OF OPERATIONS FOR RENDERING AMBULANCE SERVICES. ENTER IN COLUMN 4, IF APPLICABLE, THE FEE SCHEDULES AMOUNTS FOR THE PERIOD BEGINNING ON OR AFTER 4/1/2002.		N	0.00		0
56.01 ENTER SUBSEQUENT AMBULANCE PAYMENT LIMIT AS REQUIRED. SUBSCRIPT IF MORE THAN 2 LIMITS APPLY. ENTER IN COLUMN 4 THE FEE SCHEDULES AMOUNTS FOR INITIAL OR SUBSEQUENT PERIOD AS APPLICABLE.			0.00		0
56.02 THIRD AMBULANCE LIMIT AND FEE SCHEDULE IF NECESSARY.			0.00		0
56.03 FOURTH AMBULANCE LIMIT AND FEE SCHEDULE IF NECESSARY.			0.00		0

57 ARE YOU CLAIMING NURSING AND ALLIED HEALTH COSTS? N

58 ARE YOU AN INPATIENT REHABILITATION FACILITY(IRF), OR DO YOU CONTAIN AN IRF SUBPROVIDER? ENTER IN COLUMN 1 "Y" FOR YES AND "N" FOR NO. IF YES HAVE YOU MADE THE ELECTION FOR 100% FEDERAL PPS REIMBURSEMENT? ENTER IN COLUMN 2 "Y" FOR YES AND "N" FOR NO. THIS OPTION IS ONLY AVAILABLE FOR COST REPORTING PERIODS BEGINNING ON OR AFTER 1/1/2002 AND BEFORE 10/1/2002. N

58.01 IF LINE 58 COLUMN 1 IS Y, DOES THE FACILITY HAVE A TEACHING PROGRAM IN THE MOST RECENT COST REPORTING PERIOD ENDING ON OR BEFORE NOVEMBER 15, 2004? ENTER "Y" FOR YES OR "N" FOR NO. IS THE FACILITY TRAINING RESIDENTS IN A NEW TEACHING PROGRAM IN ACCORDANCE WITH 42 CFR SEC. 412.424(d)(1)(iii)(2)? ENTER IN COLUMN 2 "Y"FOR YES OR "N" FOR NO. IF COLUMN 2 IS Y, ENTER 1, 2 OR 3 RESPECTIVELY IN COLUMN 3 (SEE INSTRUCTIONS). IF THE CURRENT COST REPORTING PERIOD COVERS THE BEGINNING OF THE FOURTH ENTER 4 IN COLUMN 3, OR IF THE SUBSEQUENT ACADEMIC YEARS OF THE NEW TEACHING PROGRAM IN EXISTENCE, ENTER 5. (SEE INSTR). 0

59 ARE YOU A LONG TERM CARE HOSPITAL (LTCH)? ENTER IN COLUMN 1 "Y" FOR YES AND "N" FOR NO. IF YES, HAVE YOU MADE THE ELECTION FOR 100% FEDERAL PPS REIMBURSEMENT? ENTER IN COLUMN 2 "Y" FOR YES AND "N" FOR NO. (SEE INSTRUCTIONS) N

60 ARE YOU AN INPATIENT PSYCHIATRIC FACILITY (IPF), OR DO YOU CONTAIN AN IPF SUBPROVIDER? ENTER IN COLUMN 1 "Y" FOR YES AND "N" FOR NO. IF YES, IS THE IPF OR IPF SUBPROVIDER A NEW FACILITY? ENTER IN COLUMN 2 "Y" FOR YES AND "N" FOR NO. (SEE INSTRUCTIONS) N

60.01 IF LINE 60 COLUMN 1 IS Y, AND THE FACILITY IS AN IPF SUBPROVIDER, WERE RESIDENTS TRAINING IN THIS FACILITY IN ITS MOST RECENT COST REPORTING PERIOD FILED BEFORE NOV. 15, 2004? ENTER "Y" FOR YES AND "N" FOR NO. IS THIS FACILITY TRAINING RESIDENTS IN A NEW TEACHING PROGRAM IN ACCORDANCE WITH 42 CFR §412.424(d)(1)(iii)(c)? ENTER IN COL. 2 "Y" FOR YES OR "N" FOR NO. IF COL. 2 IS Y, ENTER 1, 2 OR 3 RESPECTIVELY IN COL. 3, (SEE INSTRUC). IF THE CURRENT COST REPORTING PERIOD COVERS THE BEGINNING OF THE FOURTH ENTER 4 IN COL. 3, OR IF THE SUBSEQUENT ACADEMIC YEARS OF THE NEW TEACHING PROGRAM IN EXISTENCE, ENTER 5. (SEE INSTRUC). N 0

MULTICAMPUS

61.00 IS THIS FACILITY PART OF A MULTICAMPUS HOSPITAL THAT HAS ONE OR MORE CAMPUSES IN DIFFERENT CBSA? ENTER "Y" FOR YES AND "N" FOR NO. N

IF LINE 61 IS YES, ENTER THE NAME IN COL. 0, COUNTY IN COL. 1, STATE IN COL.2, ZIP IN COL 3, CBSA IN COL. 4 AND FTE/CAMPUS IN COL. 5.

NAME	COUNTY	STATE	ZIP CODE	CBSA	FTE/CAMPUS
-----					0.00

SETTLEMENT DATA

63.00 WAS THE COST REPORT FILED USING THE PS&R (EITHER IN ITS ENTIRETY OR FOR TOTAL CHARGES AND DAYS ONLY)? ENTER "Y" FOR YES AND "N" FOR NO IN COL. 1. IF COL. 1 IS "Y", ENTER THE "PAID THROUGH" DATE OF THE PS&R IN COL. 2 (MM/DD/YYYY). Y 1/ 4/2011

COMPONENT		TITLE XIX ADMITTED 5.01	I/P DAYS / OBSERVATION BEDS NOT ADMITTED 5.02	O/P VISITS TOTAL ALL PATS 6	/ TRIPS TOTAL ADMITTED 6.01	----- OBSERVATION BEDS NOT ADMITTED 6.02	-- INTERNS & RES. FTES -- TOTAL 7	LESS I&R REPL NON-PHYS ANES 8
1	ADULTS & PEDIATRICS			5,274				
2	HMO							
2	01 HMO - (IRF PPS SUBPROVIDER)							
3	ADULTS & PED-SB SNF			326				
4	ADULTS & PED-SB NF			9				
5	TOTAL ADULTS AND PEDS			5,609				
12	TOTAL			5,609				
13	RPCH VISITS							
15	SKILLED NURSING FACILITY			4,623				
25	TOTAL							
26	OBSERVATION BED DAYS			283				
27	AMBULANCE TRIPS							
28	EMPLOYEE DISCOUNT DAYS			27				
28	01 EMP DISCOUNT DAYS -IRF							
29	LABOR & DELIVERY DAYS							

		I & R FTES	--- FULL TIME EMPLOYEES ON PAYROLL	EQUIV NONPAID WORKERS	TITLE V	DISCHARGES TITLE XVIII	TITLE XIX	TOTAL ALL PATIENTS
COMPONENT		NET 9	10	11	12	13	14	15
1	ADULTS & PEDIATRICS					1,022	165	1,427
2	HMO							
2	01 HMO - (IRF PPS SUBPROVIDER)							
3	ADULTS & PED-SB SNF							
4	ADULTS & PED-SB NF							
5	TOTAL ADULTS AND PEDS							
12	TOTAL		239.56			1,022	165	1,427
13	RPCH VISITS							
15	SKILLED NURSING FACILITY		16.86					
25	TOTAL		256.42					
26	OBSERVATION BED DAYS							
27	AMBULANCE TRIPS							
28	EMPLOYEE DISCOUNT DAYS							
28	01 EMP DISCOUNT DAYS -IRF							
29	LABOR & DELIVERY DAYS							

3,402

(1) Enter in column 3.01 the days prior to October 1st and in column 4.01 the days on after October 1st. Enter in column 4.03 the days on 4/1/2001 through 9/30/2001. The sum of the days in column 3.01, 4.01, and 4.03 must agree with the days reported on wkst. S-3, Part I, column 4, line 15. The sum of the days in column 4.06 must agree with the days reported on wkst S-3, Part I column 4, line 3.

worksheet S-2 reference data:

Transition Period	:	100% Federal
Wage Index Factor (before 10/01)	:	0.0000
Wage Index Factor (after 10/01)	:	0.8312
SNF Facility Specific Rate	:	0.00
Urban/Rural Designation	:	RURAL
SNF MSA Code	:	14
SNF CBSA Code	:	99914

1		RUC
2		RUB
3		RUA
3	.01	RUX
3	.02	RUL
4		RVC
5		RVB
6		RVA
6	.01	RVX
6	.02	RVL
7		RHC
8		RHB
9		RHA
9	.01	RHX
9	.02	RHL
10		RMC
11		RMB
12		RMA
12	.01	RMX
12	.02	RML
13		RLB
14		RLA
14	.01	RLX
15		SE3
16		SE2
17		SE1
18		SSC
19		SSB
20		SSA
21		CC2
22		CC1
23		CB2
24		CB1
25		CA2
26		CA1
27		IB2
28		IB1
29		IA2
30		IA1
31		BB2
32		BB1
33		BA2
34		BA1
35		PE2
36		PE1
37		PD2
38		PD1
39		PC2
40		PC1
41		PB2
42		PB1
43		PA2
44		PA1
45		AAA
45	.01	ES3
45	.02	ES2
45	.03	ES1
45	.04	HE2
45	.05	HE1
45	.06	HD2
45	.07	HD1
45	.08	HC2
45	.09	HC1
45	.10	HB2
45	.11	HB1
45	.12	LE2
45	.13	LE1
45	.14	LD2
45	.15	LD1
45	.16	LC2
45	.17	LC1
45	.18	LB2

GROUP(1)	M3PI REVENUE CODE	HIGH COST(2) RUGS DAYS	SWING BED SNF DAYS	TOTAL
1	2	4.05	4.06	5
45 .19 LB1				
45 .20 CE2				
45 .21 CE1				
45 .22 CD1				
45 .23 CD1				
46 TOTAL				

- (2) Enter in column 4.05 those days in either column 3.01 or 4.01 which cover the period of 4/1/2000 through 9/30/2000. These RUGs will be incremented by an additional 20% payment.
- (3) Enter in column 4.06 the swing bed days for cost reporting periods beginning on or after 7/1/2002.
- (4) Additional RUGs were published in the "Federal Register", Vol. 74 No. 153 August 11,2009, page 40286. FY 2010 SNF Final Rule These RUGs are effective for services on or after 10/01/2010.

NOTE: The default line code designation has been changed to "AAA".

worksheet S-2 reference data:

Transition Period	:	100% Federal
Wage Index Factor (before 10/01):	:	0.0000
Wage Index Factor (after 10/01) :	:	0.8312
SNF Facility Specific Rate	:	0.00
Urban/Rural Designation	:	RURAL
SNF MSA Code	:	14
SNF CBSA Code	:	99914

DESCRIPTION

UNCOMPENSATED CARE INFORMATION

1 DO YOU HAVE A WRITTEN CHARITY CARE POLICY?

2 ARE PATIENTS WRITE-OFFS IDENTIFIED AS CHARITY? IF YES ANSWER
LINES 2.01 THRU 2.04

2.01 IS IT AT THE TIME OF ADMISSION?

2.02 IS IT AT THE TIME OF FIRST BILLING?

2.03 IS IT AFTER SOME COLLECTION EFFORT HAS BEEN MADE?

2.04

3 ARE CHARITY WRITE-OFFS MADE FOR PARTIAL BILLS?

4 ARE CHARITY DETERMINATIONS BASED UPON ADMINISTRATIVE
JUDGMENT WITHOUT FINANCIAL DATA?

5 ARE CHARITY DETERMINATIONS BASED UPON INCOME DATA ONLY?

6 ARE CHARITY DETERMINATIONS BASED UPON NET WORTH (ASSETS)
DATA?

7 ARE CHARITY DETERMINATIONS BASED UPON INCOME AND NET
WORTH DATA?

8 DOES YOUR ACCOUNTING SYSTEM SEPARATELY IDENTIFY BAD
DEBT AND CHARITY CARE? IF YES ANSWER 8.01

8.01 DO YOU SEPARATELY ACCOUNT FOR INPATIENT AND OUTPATIENT
SERVICES?

9 IS DISCERNING CHARITY FROM BAD DEBT A HIGH PRIORITY IN
YOUR INSTITUTION? IF NO ANSWER 9.01 THRU 9.04

9.01 IS IT BECAUSE THERE IS NOT ENOUGH STAFF TO DETERMINE
ELIGIBILITY?

9.02 IS IT BECAUSE THERE IS NO FINANCIAL INCENTIVE TO SEPARATE
CHARITY FROM BAD DEBT?

9.03 IS IT BECAUSE THERE IS NO CLEAR DIRECTIVE POLICY ON
CHARITY DETERMINATION?

9.04 IS IT BECAUSE YOUR INSTITUTION DOES NOT DEEM THE
DISTINCTION IMPORTANT?

10 IF CHARITY DETERMINATIONS ARE MADE BASED UPON INCOME DATA,
WHAT IS THE MAXIMUM INCOME THAT CAN BE EARNED BY PATIENTS
(SINGLE WITHOUT DEPENDENT) AND STILL DETERMINED TO
BE A CHARITY WRITE OFF?

11 IF CHARITY DETERMINATIONS ARE MADE BASED UPON INCOME DATA,
IS THE INCOME DIRECTLY TIED TO FEDERAL POVERTY
LEVEL? IF YES ANSWER 11.01 THRU 11.04

11.01 IS THE PERCENTAGE LEVEL USED LESS THAN 100% OF THE FEDERAL
POVERTY LEVEL?

11.02 IS THE PERCENTAGE LEVEL USED BETWEEN 100% AND 150%
OF THE FEDERAL POVERTY LEVEL?

11.03 IS THE PERCENTAGE LEVEL USED BETWEEN 150% AND 200%
OF THE FEDERAL POVERTY LEVEL?

11.04 IS THE PERCENTAGE LEVEL USED GREATER THAN 200% OF
THE FEDERAL POVERTY LEVEL?

12 ARE PARTIAL WRITE-OFFS GIVEN TO HIGHER INCOME
PATIENTS ON A GRADUAL SCALE?

13 IS THERE CHARITY CONSIDERATION GIVEN TO HIGH NET WORTH
PATIENTS WHO HAVE CATASTROPHIC OR OTHER EXTRAORDINARY
MEDICAL EXPENSES?

14 IS YOUR HOSPITAL STATE OR LOCAL GOVERNMENT OWNED?
IF YES ANSWER LINES 14.01 AND 14.02

14.01 DO YOU RECEIVE DIRECT FINANCIAL SUPPORT FROM THAT
GOVERNMENT ENTITY FOR THE PURPOSE OF PROVIDING
COMPENSATED CARE?

14.02 WHAT PERCENTAGE OF THE AMOUNT ON LINE 14.01 IS FROM
GOVERNMENT FUNDING?

15 DO YOU RECEIVE RESTRICTED GRANTS FOR RENDERING CARE
TO CHARITY PATIENTS?

16 ARE OTHER NON-RESTRICTED GRANTS USED TO SUBSIDIZE
CHARITY CARE?

UNCOMPENSATED CARE REVENUES

17 REVENUE FROM UNCOMPENSATED CARE

17.01 GROSS MEDICAID REVENUES

18 REVENUES FROM STATE AND LOCAL INDIGENT CARE PROGRAMS

19 REVENUE RELATED TO SCHIP (SEE INSTRUCTIONS)

20 RESTRICTED GRANTS

21 NON-RESTRICTED GRANTS

22 TOTAL GROSS UNCOMPENSATED CARE REVENUES

UNCOMPENSATED CARE COST

23 TOTAL CHARGES FOR PATIENTS COVERED BY STATE AND LOCAL
INDIGENT CARE PROGRAMS

24 COST TO CHARGE RATIO (WKST C, PART I, COLUMN 3, LINE 103,
DIVIDED BY COLUMN 8, LINE 103) .436013

25 TOTAL STATE AND LOCAL INDIGENT CARE PROGRAM COST
(LINE 23 * LINE 24)

26 TOTAL SCHIP CHARGES FROM YOUR RECORDS

27 TOTAL SCHIP COST, (LINE 24 * LINE 26)

28 TOTAL GROSS MEDICAID CHARGES FROM YOUR RECORDS 10,950,716

DESCRIPTION

29	TOTAL GROSS MEDICAID COST (LINE 24 * LINE 28)	4,774,655
30	OTHER UNCOMPENSATED CARE CHARGES FROM YOUR RECORDS	3,722,149
31	UNCOMPENSATED CARE COST (LINE 24 * LINE 30)	1,622,905
32	TOTAL UNCOMPENSATED CARE COST TO THE HOSPITAL	4,774,655
	(SUM OF LINES 25, 27, AND 29)	

I PROVIDER NO:

I PERIOD:

I PREPARED 2/17/2011

RECLASSIFICATION AND ADJUSTMENT OF
TRIAL BALANCE OF EXPENSES

I 14-1339

I FROM 10/ 1/2009

I WORKSHEET A

I

I TO 9/30/2010

I

	COST CENTER	COST CENTER DESCRIPTION	SALARIES 1	OTHER 2	TOTAL 3	RECLASS- IFICATIONS 4	RECLASSIFIED TRIAL BALANCE 5
		GENERAL SERVICE COST CNTR					
3	0300	NEW CAP REL COSTS-BLDG & FIXT		220,732	220,732	64,394	285,126
4	0400	NEW CAP REL COSTS-MVBLE EQUIP		954,106	954,106	21,917	976,023
5	0500	EMPLOYEE BENEFITS	96,130	3,058,819	3,154,949		3,154,949
6	0600	ADMINISTRATIVE & GENERAL	1,703,270	3,548,853	5,252,123	-44,171	5,207,952
7	0700	MAINTENANCE & REPAIRS	538,075	57,687	595,762		595,762
8	0800	OPERATION OF PLANT	91,755	825,288	917,043		917,043
9	0900	LAUNDRY & LINEN SERVICE	94,663	53,972	148,635		148,635
10	1000	HOUSEKEEPING	274,088	81,917	356,005		356,005
11	1100	DIETARY	395,449	461,156	856,605	-536,235	320,370
12	1200	CAFETERIA				536,235	536,235
14	1400	NURSING ADMINISTRATION	318,492	36,501	354,993		354,993
15	1500	CENTRAL SERVICES & SUPPLY	41,298	224,312	265,610	-206,103	59,507
16	1600	PHARMACY	369,347	975,267	1,344,614	-922,399	422,215
17	1700	MEDICAL RECORDS & LIBRARY	448,294	92,456	540,750		540,750
18	1800	SOCIAL SERVICE	31,174	6,377	37,551		37,551
		INPAT ROUTINE SRVC CNTRS					
25	2500	ADULTS & PEDIATRICS	1,686,811	246,865	1,933,676	-42,663	1,891,013
34	3400	SKILLED NURSING FACILITY	634,245	383,355	1,017,600	-310,425	707,175
		ANCILLARY SRVC COST CNTRS					
37	3700	OPERATING ROOM	525,845	341,427	867,272	-239,239	628,033
40	4000	ANESTHESIOLOGY		813,083	813,083	-25,493	787,590
41	4100	RADIOLOGY-DIAGNOSTIC	922,962	974,754	1,897,716		1,897,716
44	4400	LABORATORY	775,618	1,019,822	1,795,440	-115	1,795,325
49	4900	RESPIRATORY THERAPY	363,274	89,270	452,544	-11,505	441,039
50	5000	PHYSICAL THERAPY	598,484	68,467	666,951	-4,836	662,115
50.01	5001	PHYSICAL THERAPY - SNF				299,691	299,691
52	5200	SPEECH PATHOLOGY	22,607	66,145	88,752		88,752
53	5300	ELECTROCARDIOLOGY	125,791	25,521	151,312	-13,272	138,040
54	5400	ELECTROENCEPHALOGRAPHY		11,360	11,360	-11,360	
55	5500	MEDICAL SUPPLIES CHARGED TO PATIENTS				476,793	476,793
55.01	5501	IMPLANTABLE DEVICES				127,961	127,961
56	5600	DRUGS CHARGED TO PATIENTS				924,378	924,378
		OUTPAT SERVICE COST CNTRS					
61	6100	EMERGENCY	976,524	1,757,147	2,733,671	-41,413	2,692,258
62	6200	OBSERVATION BEDS (NON-DISTINCT PART)					
		SPEC PURPOSE COST CENTERS					
88	8800	INTEREST EXPENSE		43,388	43,388	-43,388	
90	9000	OTHER CAPITAL RELATED COSTS					
95		SUBTOTALS	11,034,196	16,438,047	27,472,243	-1,248	27,470,995
		NONREIMBURS COST CENTERS					
96	9600	GIFT, FLOWER, COFFEE SHOP & CANTEEN					
98	9800	PHYSICIANS' PRIVATE OFFICES	-1,248	188	-1,060	1,248	188
101		TOTAL	11,032,948	16,438,235	27,471,183	-0-	27,471,183

COST CENTER		COST CENTER DESCRIPTION	ADJUSTMENTS	NET EXPENSES FOR ALLOC
			6	7
		GENERAL SERVICE COST CNTR		
3	0300	NEW CAP REL COSTS-BLDG & FIXT	4,415	289,541
4	0400	NEW CAP REL COSTS-MVBLE EQUIP	101,426	1,077,449
5	0500	EMPLOYEE BENEFITS	157,219	3,312,168
6	0600	ADMINISTRATIVE & GENERAL	-514,080	4,693,872
7	0700	MAINTENANCE & REPAIRS		595,762
8	0800	OPERATION OF PLANT		917,043
9	0900	LAUNDRY & LINEN SERVICE		148,635
10	1000	HOUSEKEEPING		356,005
11	1100	DIETARY		320,370
12	1200	CAFETERIA	-172,272	363,963
14	1400	NURSING ADMINISTRATION		354,993
15	1500	CENTRAL SERVICES & SUPPLY		59,507
16	1600	PHARMACY		422,215
17	1700	MEDICAL RECORDS & LIBRARY	-15,184	525,566
18	1800	SOCIAL SERVICE		37,551
		INPAT ROUTINE SRVC CNTRS		
25	2500	ADULTS & PEDIATRICS	-9,750	1,881,263
34	3400	SKILLED NURSING FACILITY	-6,160	701,015
		ANCILLARY SRVC COST CNTRS		
37	3700	OPERATING ROOM		628,033
40	4000	ANESTHESIOLOGY	-732,094	55,496
41	4100	RADIOLOGY-DIAGNOSTIC	-33,460	1,864,256
44	4400	LABORATORY		1,795,325
49	4900	RESPIRATORY THERAPY		441,039
50	5000	PHYSICAL THERAPY		662,115
50.01	5001	PHYSICAL THERAPY - SNF		299,691
52	5200	SPEECH PATHOLOGY		88,752
53	5300	ELECTROCARDIOLOGY	-702	137,338
54	5400	ELECTROENCEPHALOGRAPHY		
55	5500	MEDICAL SUPPLIES CHARGED TO PATIENTS		476,793
55.01	5501	IMPLANTABLE DEVICES		127,961
56	5600	DRUGS CHARGED TO PATIENTS		924,378
		OUTPAT SERVICE COST CNTRS		
61	6100	EMERGENCY	-1,388,272	1,303,986
62	6200	OBSERVATION BEDS (NON-DISTINCT PART)		
		SPEC PURPOSE COST CENTERS		
88	8800	INTEREST EXPENSE		-0-
90	9000	OTHER CAPITAL RELATED COSTS		-0-
95		SUBTOTALS	-2,608,914	24,862,081
		NONREIMBURS COST CENTERS		
96	9600	GIFT, FLOWER, COFFEE SHOP & CANTEEN		188
98	9800	PHYSICIANS' PRIVATE OFFICES		
101		TOTAL	-2,608,914	24,862,269

LINE NO.	COST CENTER DESCRIPTION	CMS CODE	STANDARD LABEL FOR NON-STANDARD CODES
	GENERAL SERVICE COST		
3	NEW CAP REL COSTS-BLDG & FIXT	0300	
4	NEW CAP REL COSTS-MVBLE EQUIP	0400	
5	EMPLOYEE BENEFITS	0500	
6	ADMINISTRATIVE & GENERAL	0600	
7	MAINTENANCE & REPAIRS	0700	
8	OPERATION OF PLANT	0800	
9	LAUNDRY & LINEN SERVICE	0900	
10	HOUSEKEEPING	1000	
11	DIETARY	1100	
12	CAFETERIA	1200	
14	NURSING ADMINISTRATION	1400	
15	CENTRAL SERVICES & SUPPLY	1500	
16	PHARMACY	1600	
17	MEDICAL RECORDS & LIBRARY	1700	
18	SOCIAL SERVICE	1800	
	INPAT ROUTINE SRVC C		
25	ADULTS & PEDIATRICS	2500	
34	SKILLED NURSING FACILITY	3400	
	ANCILLARY SRVC COST		
37	OPERATING ROOM	3700	
40	ANESTHESIOLOGY	4000	
41	RADIOLOGY-DIAGNOSTIC	4100	
44	LABORATORY	4400	
49	RESPIRATORY THERAPY	4900	
50	PHYSICAL THERAPY	5000	
50.01	PHYSICAL THERAPY - SNF	5001	PHYSICAL THERAPY
52	SPEECH PATHOLOGY	5200	
53	ELECTROCARDIOLOGY	5300	
54	ELECTROENCEPHALOGRAPHY	5400	
55	MEDICAL SUPPLIES CHARGED TO PATIENTS	5500	
55.01	IMPLANTABLE DEVICES	5501	MEDICAL SUPPLIES CHARGED TO PATIENTS
56	DRUGS CHARGED TO PATIENTS	5600	
	OUTPAT SERVICE COST		
61	EMERGENCY	6100	
62	OBSERVATION BEDS (NON-DISTINCT PART)	6200	
	SPEC PURPOSE COST CE		
88	INTEREST EXPENSE	8800	
90	OTHER CAPITAL RELATED COSTS	9000	
95	SUBTOTALS	0000	
	NONREIMBURS COST CEN		
96	GIFT, FLOWER, COFFEE SHOP & CANTEEN	9600	
98	PHYSICIANS' PRIVATE OFFICES	9800	
101	TOTAL	0000	

		INCREASE		
EXPLANATION OF RECLASSIFICATION	CODE (1) COST CENTER 1	LINE NO 3	SALARY 4	OTHER 5
1 CAFETERIA EXPENSES	A CAFETERIA	12	247,551	288,684
2 BILLABLE DRUGS	B DRUGS CHARGED TO PATIENTS	56		924,378
3				
4				
5				
6				
7 EEG EXPENSE	C RESPIRATORY THERAPY	49		11,360
8 BILLABLE SUPPLIES	D MEDICAL SUPPLIES CHARGED TO PATIENTS	55		476,793
9	IMPLANTABLE DEVICES	55.01		127,961
10				
11				
12				
13				
14				
15				
16				
17 PROPERTY INSURANCE	E OTHER CAPITAL RELATED COSTS	90		42,923
18 SNF THERAPY EXPENSE	F PHYSICAL THERAPY - SNF	50.01		299,691
19 INTEREST EXPENSE	G NEW CAP REL COSTS-BLDG & FIXT	3		43,388
20 NEGATIVE COST CENTER	H PHYSICIANS' PRIVATE OFFICES	98	1,248	
36 TOTAL RECLASSIFICATIONS			248,799	2,215,178

(1) A letter (A, B, etc) must be entered on each line to identify each reclassification entry.
 Transfer the amounts in columns 4, 5, 8, and 9 to worksheet A, column 4, lines as appropriate.
 See instructions for column 10 referencing to worksheet A-7, Part III, columns 9 through 14.

----- DECREASE -----					A-7 REF 10
EXPLANATION OF RECLASSIFICATION	CODE (1) COST CENTER 1	LINE NO 7	SALARY 8	OTHER 9	
1 CAFETERIA EXPENSES	A	DIETARY 11	247,551	288,684	
2 BILLABLE DRUGS	B	PHARMACY 16		922,399	
3		OPERATING ROOM 37		833	
4		ANESTHESIOLOGY 40		938	
5		LABORATORY 44		115	
6		RESPIRATORY THERAPY 49		93	
7 EEG EXPENSE	C	ELECTROENCEPHALOGRAPHY 54		11,360	
8 BILLABLE SUPPLIES	D	CENTRAL SERVICES & SUPPLY 15		206,103	
9		ADULTS & PEDIATRICS 25		42,663	
10		SKILLED NURSING FACILITY 34		10,734	
11		OPERATING ROOM 37		238,406	
12		ANESTHESIOLOGY 40		24,555	
13		RESPIRATORY THERAPY 49		22,772	
14		PHYSICAL THERAPY 50		4,836	
15		ELECTROCARDIOLOGY 53		13,272	
16		EMERGENCY 61		41,413	
17 PROPERTY INSURANCE	E	ADMINISTRATIVE & GENERAL 6		42,923	
18 SNF THERAPY EXPENSE	F	SKILLED NURSING FACILITY 34		299,691	
19 INTEREST EXPENSE	G	INTEREST EXPENSE 88		43,388	14
20 NEGATIVE COST CENTER	H	ADMINISTRATIVE & GENERAL 6	1,248		
36 TOTAL RECLASSIFICATIONS			248,799	2,215,178	

(1) A letter (A, B, etc) must be entered on each line to identify each reclassification entry.
 Transfer the amounts in columns 4, 5, 8, and 9 to worksheet A, column 4, lines as appropriate.
 See instructions for column 10 referencing to worksheet A-7, Part III, columns 9 through 14.

RECLASS CODE: A
EXPLANATION : CAFETERIA EXPENSES

----- INCREASE -----			----- DECREASE -----		
LINE	COST CENTER	AMOUNT	LINE	COST CENTER	AMOUNT
1.00	CAFETERIA	536,235	11	DIETARY	536,235
TOTAL RECLASSIFICATIONS FOR CODE A		536,235			

RECLASS CODE: B
EXPLANATION : BILLABLE DRUGS

----- INCREASE -----			----- DECREASE -----		
LINE	COST CENTER	AMOUNT	LINE	COST CENTER	AMOUNT
1.00	DRUGS CHARGED TO PATIENTS	924,378	16	PHARMACY	922,399
2.00		0	37	OPERATING ROOM	833
3.00		0	40	ANESTHESIOLOGY	938
4.00		0	44	LABORATORY	115
5.00		0	49	RESPIRATORY THERAPY	93
TOTAL RECLASSIFICATIONS FOR CODE B		924,378	924,378		

RECLASS CODE: C
EXPLANATION : EEG EXPENSE

----- INCREASE -----			----- DECREASE -----		
LINE	COST CENTER	AMOUNT	LINE	COST CENTER	AMOUNT
1.00	RESPIRATORY THERAPY	11,360	54	ELECTROENCEPHALOGRAPHY	11,360
TOTAL RECLASSIFICATIONS FOR CODE C		11,360	11,360		

RECLASS CODE: D
EXPLANATION : BILLABLE SUPPLIES

----- INCREASE -----			----- DECREASE -----		
LINE	COST CENTER	AMOUNT	LINE	COST CENTER	AMOUNT
1.00	MEDICAL SUPPLIES CHARGED TO PA	476,793	15	CENTRAL SERVICES & SUPPLY	206,103
2.00	IMPLANTABLE DEVICES	127,961	25	ADULTS & PEDIATRICS	42,663
3.00		0	34	SKILLED NURSING FACILITY	10,734
4.00		0	37	OPERATING ROOM	238,406
5.00		0	40	ANESTHESIOLOGY	24,555
6.00		0	49	RESPIRATORY THERAPY	22,772
7.00		0	50	PHYSICAL THERAPY	4,836
8.00		0	53	ELECTROCARDIOLOGY	13,272
9.00		0	61	EMERGENCY	41,413
TOTAL RECLASSIFICATIONS FOR CODE D		604,754	604,754		

RECLASS CODE: E
EXPLANATION : PROPERTY INSURANCE

----- INCREASE -----			----- DECREASE -----		
LINE	COST CENTER	AMOUNT	LINE	COST CENTER	AMOUNT
1.00	OTHER CAPITAL RELATED COSTS	42,923	6	ADMINISTRATIVE & GENERAL	42,923
TOTAL RECLASSIFICATIONS FOR CODE E		42,923	42,923		

RECLASS CODE: F
EXPLANATION : SNF THERAPY EXPENSE

----- INCREASE -----			----- DECREASE -----		
LINE	COST CENTER	AMOUNT	LINE	COST CENTER	AMOUNT
1.00	PHYSICAL THERAPY - SNF	299,691	34	SKILLED NURSING FACILITY	299,691
TOTAL RECLASSIFICATIONS FOR CODE F		299,691	299,691		

RECLASS CODE: G
EXPLANATION : INTEREST EXPENSE

----- INCREASE -----			----- DECREASE -----		
LINE	COST CENTER	AMOUNT	LINE	COST CENTER	AMOUNT
1.00	NEW CAP REL COSTS-BLDG & FIXT	43,388	88	INTEREST EXPENSE	43,388
TOTAL RECLASSIFICATIONS FOR CODE G		43,388	43,388		

RECLASS CODE: H
EXPLANATION : NEGATIVE COST CENTER

----- INCREASE -----			----- DECREASE -----		
LINE	COST CENTER	AMOUNT	LINE	COST CENTER	AMOUNT
1.00	PHYSICIANS' PRIVATE OFFICES	1,248	6	ADMINISTRATIVE & GENERAL	1,248
TOTAL RECLASSIFICATIONS FOR CODE H		1,248	1,248		

PART I - ANALYSIS OF CHANGES IN OLD CAPITAL ASSET BALANCES

DESCRIPTION		BEGINNING BALANCES 1	PURCHASES 2	ACQUISITIONS DONATION 3	TOTAL 4	DISPOSALS AND RETIREMENTS 5	ENDING BALANCE 6	FULLY DEPRECIATED ASSETS 7
1	LAND							
2	LAND IMPROVEMENTS							
3	BUILDINGS & FIXTURE							
4	BUILDING IMPROVEMEN							
5	FIXED EQUIPMENT							
6	MOVABLE EQUIPMENT							
7	SUBTOTAL							
8	RECONCILING ITEMS							
9	TOTAL							

PART II - ANALYSIS OF CHANGES IN NEW CAPITAL ASSET BALANCES

DESCRIPTION		BEGINNING BALANCES 1	PURCHASES 2	ACQUISITIONS DONATION 3	TOTAL 4	DISPOSALS AND RETIREMENTS 5	ENDING BALANCE 6	FULLY DEPRECIATED ASSETS 7
1	LAND	642,244					642,244	
2	LAND IMPROVEMENTS	700,369				43,076	657,293	626,841
3	BUILDINGS & FIXTURE	8,607,743	10,048,943		10,048,943	254,338	18,402,348	1,892,651
4	BUILDING IMPROVEMEN							
5	FIXED EQUIPMENT							
6	MOVABLE EQUIPMENT	20,164,319	1,072,400		1,072,400	1,350,512	19,886,207	12,079,008
7	SUBTOTAL	30,114,675	11,121,343		11,121,343	1,647,926	39,588,092	14,598,500
8	RECONCILING ITEMS							
9	TOTAL	30,114,675	11,121,343		11,121,343	1,647,926	39,588,092	14,598,500

PART III - RECONCILIATION OF CAPITAL COST CENTERS

DESCRIPTION		COMPUTATION OF RATIOS				ALLOCATION OF OTHER CAPITAL			TOTAL
		GROSS ASSETS	CAPITIALIZED LEASES	GROSS ASSETS FOR RATIO	RATIO	INSURANCE	TAXES	OTHER CAPITAL RELATED COSTS	
*		1	2	3	4	5	6	7	8
3	NEW CAP REL COSTS-BL	19,059,641		19,059,641	.489388	21,006			21,006
4	NEW CAP REL COSTS-MV	19,886,207		19,886,207	.510612	21,917			21,917
5	TOTAL	38,945,848		38,945,848	1.000000	42,923			42,923

DESCRIPTION SUMMARY OF OLD AND NEW CAPITAL

		DEPRECIATION	LEASE	INTEREST	INSURANCE	TAXES	OTHER CAPITAL RELATED COST	TOTAL (1)
*		9	10	11	12	13	14	15
3	NEW CAP REL COSTS-BL	225,147			21,006		43,388	289,541
4	NEW CAP REL COSTS-MV	1,055,532			21,917			1,077,449
5	TOTAL	1,280,679			42,923		43,388	1,366,990

PART IV - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 THRU 4

DESCRIPTION		SUMMARY OF OLD AND NEW CAPITAL						TOTAL (1)
		DEPRECIATION	LEASE	INTEREST	INSURANCE	TAXES	OTHER CAPITAL RELATED COST	
*		9	10	11	12	13	14	15
3	NEW CAP REL COSTS-BL	220,732						220,732
4	NEW CAP REL COSTS-MV	954,106						954,106
5	TOTAL	1,174,838						1,174,838

- * All lines numbers except line 5 are to be consistent with workhseet A line numbers for capital cost centers.
- (1) The amounts on lines 1 thru 4 must equal the corresponding amounts on worksheet A, column 7, lines 1 thru 4. Columns 9 through 14 should include related worksheet A-6 reclassifications and worksheet A-8 adjustments. (See instructions).

DESCRIPTION (1)		(2) BASIS/CODE 1	AMOUNT 2	EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED COST CENTER 3	LINE NO 4	WKST. A-7 REF. 5
1	INVEST INCOME-OLD BLDGS AND FIXTURES			**COST CENTER DELETED**	1	
2	INVESTMENT INCOME-OLD MOVABLE EQUIP			**COST CENTER DELETED**	2	
3	INVEST INCOME-NEW BLDGS AND FIXTURES			NEW CAP REL COSTS-BLDG &	3	
4	INVESTMENT INCOME-NEW MOVABLE EQUIP			NEW CAP REL COSTS-MVBLE E	4	
5	INVESTMENT INCOME-OTHER	B	-13,349	ADMINISTRATIVE & GENERAL	6	
6	TRADE, QUANTITY AND TIME DISCOUNTS	B	-21,725	ADMINISTRATIVE & GENERAL	6	
7	REFUNDS AND REBATES OF EXPENSES					
8	RENTAL OF PROVIDER SPACE BY SUPPLIERS					
9	TELEPHONE SERVICES	A	-245	NEW CAP REL COSTS-MVBLE E	4	9
10	TELEVISION AND RADIO SERVICE	A	-6,671	NEW CAP REL COSTS-MVBLE E	4	9
11	PARKING LOT					
12	PROVIDER BASED PHYSICIAN ADJUSTMENT	A-8-2	-2,169,778			
13	SALE OF SCRAP, WASTE, ETC.	B	-660	RADIOLOGY-DIAGNOSTIC	41	
14	RELATED ORGANIZATION TRANSACTIONS	A-8-1	250,225			
15	LAUNDRY AND LINEN SERVICE					
16	CAFETERIA--EMPLOYEES AND GUESTS	B	-147,764	CAFETERIA	12	
17	RENTAL OF QTRS TO EMPLOYEE AND OTHERS					
18	SALE OF MED AND SURG SUPPLIES					
19	SALE OF DRUGS TO OTHER THAN PATIENTS					
20	SALE OF MEDICAL RECORDS & ABSTRACTS	B	-15,184	MEDICAL RECORDS & LIBRARY	17	
21	NURSG SCHOOL(TUITN,FEES,BOOKS, ETC.)					
22	VENDING MACHINES					
23	INCOME FROM IMPOSITION OF INTEREST					
24	INTRST EXP ON MEDICARE OVERPAYMENTS					
25	ADJUSTMENT FOR RESPIRATORY THERAPY	A-8-3/A-8-4		RESPIRATORY THERAPY	49	
26	ADJUSTMENT FOR PHYSICAL THERAPY	A-8-3/A-8-4		PHYSICAL THERAPY	50	
27	ADJUSTMENT FOR HHA PHYSICAL THERAPY	A-8-3				
28	UTILIZATION REVIEW-PHYSIAN COMP			**COST CENTER DELETED**	89	
29	DEPRECIATION-OLD BLDGS AND FIXTURES			**COST CENTER DELETED**	1	
30	DEPRECIATION-OLD MOVABLE EQUIP			**COST CENTER DELETED**	2	
31	DEPRECIATION-NEW BLDGS AND FIXTURES			NEW CAP REL COSTS-BLDG &	3	
32	DEPRECIATION-NEW MOVABLE EQUIP			NEW CAP REL COSTS-MVBLE E	4	
33	NON-PHYSICIAN ANESTHETIST			**COST CENTER DELETED**	20	
34	PHYSICIANS' ASSISTANT					
35	ADJUSTMENT FOR OCCUPATIONAL THERAPY	A-8-4		**COST CENTER DELETED**	51	
36	ADJUSTMENT FOR SPEECH PATHOLOGY	A-8-4		SPEECH PATHOLOGY	52	
37	PROVIDER TAX EXPENSE	A	-372,120	ADMINISTRATIVE & GENERAL	6	
38	MUTUAL ASSISTANCE PROGRAM EXPENSE	A	-21,960	ADMINISTRATIVE & GENERAL	6	
39	CASH MANAGEMENT FEE	B	38,975	ADMINISTRATIVE & GENERAL	6	
40	MISCELLANEOUS REVENUE - GUEST MEALS	B	-24,508	CAFETERIA	12	
41	TELEPHONE SALARY EXPENSE	A	-3,318	ADMINISTRATIVE & GENERAL	6	
42	TELEPHONE OTHER EXPENSE	A	-2,745	ADMINISTRATIVE & GENERAL	6	
43	TELEPHONE BENEFIT EXPENSE	A	-998	EMPLOYEE BENEFITS	5	
44	MARKETING SALARY EXPENSE	A	-13,004	ADMINISTRATIVE & GENERAL	6	
45	MARKETING FICA EXPENSE	A	-954	ADMINISTRATIVE & GENERAL	6	
46	MARKETING BENEFIT EXPENSE	A	-3,910	EMPLOYEE BENEFITS	5	
47	ADVERTISING EXPENSE	A	-69,727	ADMINISTRATIVE & GENERAL	6	
48	MARKETING OTHER EXPENSE	A	6,709	ADMINISTRATIVE & GENERAL	6	
49	LOBBYING EXPENSE	A	-16,203	ADMINISTRATIVE & GENERAL	6	
50	TOTAL (SUM OF LINES 1 THRU 49)		-2,608,914			

(1) Description - all chapter references in this column pertain to CMS Pub. 15-I.

(2) Basis for adjustment (see instructions).

A. Costs - if cost, including applicable overhead, can be determined.

B. Amount Received - if cost cannot be determined.

(3) Additional adjustments may be made on lines 37 thru 49 and subscripts thereof.

Note: See instructions for column 5 referencing to worksheet A-7

A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR THE CLAIMING OF HOME OFFICE COSTS:

LINE NO.	COST CENTER	EXPENSE ITEMS	AMOUNT OF ALLOWABLE COST	AMOUNT	NET* ADJUSTMENTS	WKSHT A-7 COL. REF.
1	2	3	4	5	6	
1	3	NEW CAP REL COSTS-BLDG & CAPITAL BLDG HO BLDG CAP	4,415		4,415	9
2	4	NEW CAP REL COSTS-MVBLE E CAPITAL MME HO MME CAPITA	108,342		108,342	9
3	6	ADMINISTRATIVE & GENERAL CAPITAL BLDG HO INTEREST	13,349		13,349	
4	6	ADMINISTRATIVE & GENERAL A&G HO MANAGEMENT	1,635,275	1,673,283	-38,008	
4.01	5	EMPLOYEE BENEFITS HEALTH INSURANCE	2,801,101	2,638,974	162,127	
4.02	6	ADMINISTRATIVE & GENERAL A&G ITEMS - ALMH	2,305	2,305		
4.03	6	ADMINISTRATIVE & GENERAL A&G ITEMS - MMC	1,124,905	1,124,905		
4.04	6	ADMINISTRATIVE & GENERAL A&G ITEMS - MHS	246,365	246,365		
5		TOTALS	5,936,057	5,685,832	250,225	

* THE AMOUNTS ON LINES 1-4 AND SUBSCRIPTS AS APPROPRIATE ARE TRANSFERRED IN DETAIL TO WORKSHEET A, COLUMN 6, LINES AS APPROPRIATE. POSITIVE AMOUNTS INCREASE COST AND NEGATIVE AMOUNTS DECREASE COST. FOR RELATED ORGANIZATIONAL OR HOME OFFICE COST WHICH HAS NOT BEEN POSTED TO WORKSHEET A, COLUMNS 1 AND/OR 2, THE AMOUNT ALLOWABLE SHOULD BE IN COLUMN 4 OF THIS PART.

B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:
THE SECRETARY, BY VIRTUE OF AUTHORITY GRANTED UNDER SECTION 1814(B)(1) OF THE SOCIAL SECURITY ACT, REQUIRES THAT YOU FURNISH THE INFORMATION REQUESTED UNDER PART B OF THIS WORKSHEET.

THIS INFORMATION IS USED BY THE CENTERS FOR MEDICARE & MEDICAID SERVICES AND ITS INTERMEDIARIES IN DETERMINING THAT THE COSTS APPLICABLE TO SERVICES, FACILITIES, AND SUPPLIES FURNISHED BY ORGANIZATIONS RELATED TO YOU BY COMMON OWNERSHIP OR CONTROL REPRESENT REASONABLE COSTS AS DETERMINED UNDER SECTION 1861 OF THE SOCIAL SECURITY ACT. IF YOU DO NOT PROVIDE ALL OR ANY PART OF THE REQUESTED INFORMATION, THE COST REPORT IS CONSIDERED INCOMPLETE AND NOT ACCEPTABLE FOR PURPOSES OF CLAIMING REIMBURSEMENT UNDER TITLE XVIII.

SYMBOL (1)	NAME	PERCENTAGE OF OWNERSHIP	RELATED ORGANIZATION(S) AND/OR HOME OFFICE NAME	PERCENTAGE OF OWNERSHIP	TYPE OF BUSINESS
1	2	3	4	5	6
1	B	0.00	MEMORIAL HEALTH SYSTEM	100.00	MANAGEMENT HOME OFFICE
2	B	0.00	MEMORIAL MEDICAL CENTER	0.00	HOSPITAL
3	B	0.00	ABRAHAM LINCOLN MEMORIAL	0.00	HOSPITAL
4	B	0.00	MEMORIAL HOME SERVICES, N	0.00	HOME HEALTH
5		0.00		0.00	

(1) USE THE FOLLOWING SYMBOLS TO INDICATE INTERRELATIONSHIP TO RELATED ORGANIZATIONS:

- INDIVIDUAL HAS FINANCIAL INTEREST (STOCKHOLDER, PARTNER, ETC.) IN BOTH RELATED ORGANIZATION AND IN PROVIDER.
- CORPORATION, PARTNERSHIP OR OTHER ORGANIZATION HAS FINANCIAL INTEREST IN PROVIDER.
- PROVIDER HAS FINANCIAL INTEREST IN CORPORATION, PARTNERSHIP OR OTHER ORGANIZATION.
- DIRECTOR, OFFICER, ADMINISTRATOR OR KEY PERSON OF PROVIDER OR RELATIVE OF SUCH PERSON HAS A FINANCIAL INTEREST IN RELATED ORGANIZATION.
- INDIVIDUAL IS DIRECTOR, OFFICER, ADMINISTRATOR OR KEY PERSON OF PROVIDER AND RELATED ORGANIZATION.
- DIRECTOR, OFFICER, ADMINISTRATOR OR KEY PERSON OF RELATED ORGANIZATION OR RELATIVE OF SUCH PERSON HAS FINANCIAL INTEREST IN PROVIDER.
- OTHER (FINANCIAL OR NON-FINANCIAL) SPECIFY.

WKSHT A LINE NO.	COST CENTER/ PHYSICIAN IDENTIFIER	TOTAL REMUN- ERATION	PROFES- SIONAL COMPONENT	PROVIDER COMPONENT	RCE AMOUNT	PHYSICIAN/ PROVIDER COMPONENT HOURS	UNADJUSTED RCE LIMIT	5 PERCENT OF UNADJUSTED RCE LIMIT
1	2	3	4	5	6	7	8	9
1 49	RESPIRATORY THERAPY/ AGGR	3,630		3,630				
2 44	LABORATORY/ AGGREGATE	22,917		22,917				
3 41	ECHOCARDIOLOGY/ AGGREGATE	32,800	32,800					
4 53	EKG/ AGGREGATE	702	702					
5 61	ER/ AGGREGATE	1,621,013	1,388,272	232,741				
6 25	ACUTE CARE/ AGGREGATE	9,750	9,750					
7 40	ANESTHESIA/ AGGREGATE	750,094	732,094	18,000				
8 34	SKILLED NURSING/ AGGREGAT	6,160	6,160					
9								
10								
11								
12								
13								
14								
15								
16								
17								
18								
19								
20								
21								
22								
23								
24								
25								
26								
27								
28								
29								
30								
101	TOTAL	2,447,066	2,169,778	277,288				

WKSHT A LINE NO.	COST CENTER/ PHYSICIAN IDENTIFIER	COST OF MEMBERSHIPS & CONTINUING EDUCATION	PROVIDER COMPONENT SHARE OF	PHYSICIAN COST OF MALPRACTICE INSURANCE	PROVIDER COMPONENT SHARE OF	ADJUSTED RCE LIMIT	RCE DIS- ALLOWANCE	ADJUSTMENT
10	11	12	13	14	15	16	17	18
1 49	RESPIRATORY THERAPY/ AGGR							
2 44	LABORATORY/ AGGREGATE							
3 41	ECHOCARDIOLOGY/ AGGREGATE							32,800
4 53	EKG/ AGGREGATE							702
5 61	ER/ AGGREGATE							1,388,272
6 25	ACUTE CARE/ AGGREGATE							9,750
7 40	ANESTHESIA/ AGGREGATE							732,094
8 34	SKILLED NURSING/ AGGREGAT							6,160
9								
10								
11								
12								
13								
14								
15								
16								
17								
18								
19								
20								
21								
22								
23								
24								
25								
26								
27								
28								
29								
30								
101	TOTAL							2,169,778

PART I - GENERAL INFORMATION

1	TOTAL NUMBER OF WEEKS WORKED (EXCLUDING AIDES) (SEE INSTRUCTIONS)	52
2	LINE 1 MULTIPLIED BY 15 HOURS PER WEEK	780
3	NUMBER OF UNDUPLICATED DAYS IN WHICH SUPERVISOR OR THERAPIST WAS ON PROVIDER SITE (SEE INSTRUCTIONS)	240
4	NUMBER OF UNDUPLICATED DAYS IN WHICH THERAPY ASSISTANT WAS ON PROVIDER SITE BUT NEITHER SUPERVISOR NOR THERAPIST WAS ON PROVIDER SITE (SEE INSTRUCTIONS)	
5	NUMBER OF UNDUPLICATED OFFSITE VISITS - SUPERVISORS OR THERAPISTS (SEE INSTRUCTIONS)	
6	NUMBER OF UNDUPLICATED OFFSITE VISITS - THERAPY ASSISTANTS (INCLUDE ONLY VISITS MADE BY THERAPY ASSISTANT AND ON WHICH SUPERVISOR AND/OR THERAPIST WAS NOT PRESENT DURING THE VISIT(S)) (SEE INSTRUCTIONS)	
7	STANDARD TRAVEL EXPENSE RATE	3.45
8	OPTIONAL TRAVEL EXPENSE RATE PER MILE	

	SUPERVISORS 1	THERAPISTS 2	ASSISTANTS 3	AIDES 4	TRAINEES 5
9	TOTAL HOURS WORKED	1049.50			
10	AHSEA (SEE INSTRUCTIONS)	66.94			
11	STANDARD TRAVEL ALLOWANCE (COLUMNS 1 AND 2, ONE- HALF OF COLUMN 2, LINE 10; COLUMN 3, ONE-HALF OF COLUMN 3, LINE 10)	33.47	33.47		
12	NUMBER OF TRAVEL HOURS (SEE INSTRUCTIONS)				
12.01	NUMBER OF TRAVEL HOURS OFFSITE (SEE INSTRUCTIONS)				
13	NUMBER OF MILES DRIVEN (SEE INSTRUCTIONS)				
13.01	NUMBER OF MILES DRIVEN OFFSITE (SEE INSTRUCTIONS)				

PART II - SALARY EQUIVALENCY COMPUTATION

14	SUPERVISORS (COLUMN 1, LINE 9 TIMES COLUMN 1, LINE 10)	
15	THERAPISTS (COLUMN 2, LINE 9 TIMES COLUMN 2, LINE 10)	70,254
16	ASSISTANTS (COLUMN 3, LINE 9 TIMES COLUMN 3, LINE 10)	
17	SUBTOTAL ALLOWANCE AMOUNT (SUM LNS 14 & 15 FOR RT OR LINES 14-16 FOR ALL OTHERS)	70,254
18	AIDES (COLUMN 4, LINE 9 TIMES COLUMN 4, LINE 10)	
19	TRAINEES (COLUMN 5, LINE 9 TIMES COLUMN 5, LINE 10)	
20	TOTAL ALLOWANCE AMOUNT (SUM OF LNS 17-19 FOR RT OR LINES 17 AND 18 FOR ALL OTHERS)	70,254

IF THE SUM OF COLUMNS 1 AND 2 FOR RESPIRATORY THERAPY OR COLUMNS 1-3 FOR PHYSICAL THERAPY, SPEECH PATHOLOGY OR OCCUPATIONAL THERAPY, LINE 9, IS GREATER THAN LINE 2, MAKE NO ENTRIES ON LINES 21 AND 22 AND ENTER ON LINE 23 THE AMOUNT FROM LINE 20.
OTHERWISE COMPLETE LINES 21-23.

21	WEIGHTED AVERAGE RATE EXCLUDING AIDES AND TRAINEES (SEE INSTRUCTIONS)	
22	WEIGHTED ALLOWANCE EXCLUDING AIDES AND TRAINEES (SEE INSTRUCTIONS)	
23	TOTAL SALARY EQUIVALENCY (SEE INSTRUCTIONS)	70,254

PART III - SALARY AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE

24	STANDARD TRAVEL ALLOWANCE THERAPISTS (LINE 3 TIMES COLUMN 2, LINE 11)	8,033
25	ASSISTANTS (LINE 4 TIMES COLUMN 3, LINE 11)	
26	SUBTOTAL (LN 24 FOR RT OR SUM LN 24&25 ALL OTHERS)	8,033
27	STANDARD TRAVEL EXPENSE (LINE 7 TIMES SUM OF LINES 3 AND 4)	828
28	TOTAL STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE AT THE PROVIDER SITE (SUM OF LINES 26 AND 27)	8,861
29	OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE THERAPISTS (COLUMN 2, LINE 10 TIMES THE SUM OF COLUMNS 1 AND 2, LINE 12)	
30	ASSISTANTS (COLUMN 3, LINE 10 TIMES COLUMN 3, LINE 12)	
31	SUBTOTAL (LN 29 FOR RT OR SUM LN 29&30 ALL OTHERS)	
32	OPTIONAL TRAVEL EXPENSE (LN8 TIMES COLUMNS 1 & 2, LN 13 FOR RT OR SUM OF COLS 1-3, LN 13 ALL OTHERS)	

SPEECH PATHOLOGY

33 STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (LINE 28) 8,861

34 OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (SUM OF LINES 27 AND 30)

35 OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE (SUM OF LINES 31 AND 32)

PART IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE

STANDARD TRAVEL EXPENSE

36 THERAPISTS (LINE 5 TIMES COLUMN 2, LINE 11)

37 ASSISTANTS (LINE 6 TIMES COLUMN 3, LINE 11)

38 SUBTOTAL (SUM OF LINES 36 AND 37)

39 STANDARD TRAVEL EXPENSE (LINE 7 TIMES THE SUM OF LINES 5 AND 6)

40 THERAPISTS (SUM OF COLUMNS 1 AND 2, LINE 12 TIMES COLUMN 2, LINE 10)

41 ASSISTANTS (COLUMN 3, LINE 12 TIMES COLUMN 3, LINE 10)

42 SUBTOTAL (SUM OF LINES 40 AND 41)

43 OPTIONAL TRAVEL EXPENSE (LINE 8 TIMES THE SUM OF COLUMNS 1-3, LINE 13)

TOTAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE - OFFSITE SERVICES; COMPLETE ONE OF THE FOLLOWING THREE LINES 44, 45, OR 46 AS APPROPRIATE

44 STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (SUM OF LINES 38 AND 39 - SEE INSTRUCTIONS)

45 OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (SUM OF LINES 39 AND 42 - SEE INSTRUCTIONS)

46 OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE (SUM OF LINES 42 AND 43 - SEE INSTRUCTIONS)

PART V - OVERTIME COMPUTATION

	THERAPISTS	ASSISTANTS	AIDES	TRAINEES	TOTAL
	1	2	3	4	5
47 OVERTIME HOURS WORKED DURING REPORTING PERIOD (IF COLUMN 5, LINE 47, IS ZERO OR EQUAL TO OR GREATER THAN 2,080, DO NOT COMPLETE LINES 48-55 AND ENTER ZERO IN EACH COLUMN OF LINE 56)					
48 OVERTIME RATE (SEE INSTRUCTIONS)					
CALCULATION OF LIMIT					
49 TOTAL OVERTIME (INCLUDING BASE AND OVERTIME ALLOWANCE)(MULTIPLY LINE 47 TIMES LINE 48)					
50 PERCENTAGE OF OVERTIME HOURS BY CATEGORY (DIVIDE THE HOURS IN EACH COLUMN ON LINE 47 BY THE TOTAL OVERTIME WORKED - COLUMN 5, LINE 47)	100.00				100.00
51 ALLOCATION OF PROVIDER'S STANDARD WORKYEAR FOR ONE FULL-TIME EMPLOYEE TIME THE PERCENTAGES ON LINE 50 (SEE INSTRUCTIONS)					
DETERMINATION OF OVERTIME ALLOWANCE					
52 ADJUSTED HOURLY SALARY EQUIVALENCY AMOUNT (SEE INSTRUCTIONS)					
53 OVERTIME COST LIMITATION (LINE 51 TIMES LINE 52)					
54 MAXIMUM OVERTIME COST (ENTER THE LESSOR OF LINE 49 OR LINE 53)					
55 PORTION OF OVERTIME ALREADY INCLUDED IN HOURLY COMPUTATION AT THE AHSEA (MULTIPLY LINE 47 TIMES LINE 52)					
56 OVERTIME ALLOWANCE (LINE 54 MINUS LINE 55 - IF NEGATIVE ENTER ZERO)(ENTER IN COLUMN 5 THE SUM OF COLUMNS 1, 3, AND 4 FOR RESPIRATORY THERAPY AND COLUMNS 1 THROUGH 3 FOR ALL OTHERS.)					

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

57 SALARY EQUIVALENCY AMOUNT (FROM PART II, LINE 23) 70,254

58 TRAVEL ALLOWANCE AND EXPENSE - PROVIDER SITE (FROM PART III, LINE 33, 34, OR 35) 8,861

59 TRAVEL ALLOWANCE AND EXPENSE - OFFSITE SERVICES (FROM PART IV, LINES 44, 45, OR 46)

60 OVERTIME ALLOWANCE(FROM COLUMN 5, LINE 56)

61 EQUIPMENT COST (SEE INSTRUCTIONS)

62 SUPPLIES (SEE INSTRUCTIONS)

63 TOTAL ALLOWANCE (SUM OF LINES 57-62) 79,115

64 TOTAL COST OF OUTSIDE SUPPLIER SERVICES (FROM YOUR RECORDS) 64,195

SPEECH PATHOLOGY

65 EXCESS OVER LIMITATION (LINE 64 MINUS LINE 63 - IF
NEGATIVE, ENTER ZERO -- SEE INSTRUCTIONS)

PART VII - ALLOCATION OF THERAPY EXCESS COST OVER LIMITATION FOR NONSHARED THERAPY DEPARTMENT SERVICES
66 COST OF OUTSIDE SUPPLIER SERVICES - 64,195
(SEE INSTRUCTIONS)(FROM YOUR RECORDS)

66.01 COST OF OUTSIDE SUPPLIER SERVICES - CORF I
(SEE INSTRUCTIONS)(FROM YOUR RECORDS)

66.31 COST OF OUTSIDE SUPPLIER SERVICES - HHA I
(SEE INSTRUCTIONS)(FROM YOUR RECORDS)

67 TOTAL COST (SUM OF LINE 66 AND SUBSCRIPTS)(THIS
LINE MUST AGREE WITH LINE 64) 64,195

68 RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO
TOTAL COST- (LINE 66 DIVIDED BY LINE 67) 1.000000

68.01 RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO
TOTAL COST-CORF I (LINE 66 DIVIDED BY LINE 67)

68.31 RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO
TOTAL COST- HHA I (LINE 66 DIVIDED BY LINE 67)

69 EXCESS COST OVER LIMITATION-
(SEE INSTRUCTIONS)(TRANSFER TO WKST. A-8, LINES
AS INDICATED IN INSTRUCTIONS)

69.01 EXCESS COST OVER LIMITATION-CORF I
(SEE INSTRUCTIONS)(TRANSFER TO WKST. A-8, LINES
AS INDICATED IN INSTRUCTIONS)

69.31 EXCESS COST OVER LIMITATION- HHA I
(SEE INSTRUCTIONS)(TRANSFER TO WKST. A-8, LINES
AS INDICATED IN INSTRUCTIONS)

70 TOTAL EXCESS OF COST OVER LIMITATION (SUM OF LINE
69 AND SUBSCRIPTS OF LINE 69)(THIS LINE MUST AGREE
WITH LINE 65)

I PROVIDER NO:

I PERIOD:

I PREPARED 2/17/2011

COST ALLOCATION STATISTICS

I 14-1339

I FROM 10/ 1/2009

I NOT A CMS WORKSHEET

I

I TO 9/30/2010

I

LINE NO.	COST CENTER DESCRIPTION	STATISTICS CODE	STATISTICS DESCRIPTION		
	GENERAL SERVICE COST				
3	NEW CAP REL COSTS-BLDG & FIXT	3	SQUARE	FEET	ENTERED
4	NEW CAP REL COSTS-MVBLE EQUIP	4	DOLLAR	VALUE	ENTERED
5	EMPLOYEE BENEFITS	5	GROSS	SALARIES	ENTERED
6	ADMINISTRATIVE & GENERAL	#	ACCUM.	COST	NOT ENTERED
7	MAINTENANCE & REPAIRS	6	HOURS OF	SERVICE	ENTERED
8	OPERATION OF PLANT	3	SQUARE	FEET	ENTERED
9	LAUNDRY & LINEN SERVICE	8	POUNDS OF	LAUNDRY	ENTERED
10	HOUSEKEEPING	9	HOURS OF	SERVICE	ENTERED
11	DIETARY	10	MEALS	SERVED	ENTERED
12	CAFETERIA	11	MEALS	SERVED	ENTERED
14	NURSING ADMINISTRATION	13	DIRECT	NRSING HRS	ENTERED
15	CENTRAL SERVICES & SUPPLY	14	COSTED	REQUIS.	ENTERED
16	PHARMACY	15	COSTED	REQUIS.	ENTERED
17	MEDICAL RECORDS & LIBRARY	16	TIME	SPENT	ENTERED
18	SOCIAL SERVICE	17	TIME	SPENT	ENTERED

	COST CENTER DESCRIPTION	NET EXPENSES FOR COST ALLOCATION	NEW CAP REL C OSTS-BLDG &	NEW CAP REL C OSTS-MVBLE E	EMPLOYEE BENE FITS	SUBTOTAL	ADMINISTRATIV E & GENERAL	MAINTENANCE & REPAIRS
		0	3	4	5	5a.00	6	7
003	GENERAL SERVICE COST CNTR							
004	NEW CAP REL COSTS-BLDG &	289,541	289,541					
005	NEW CAP REL COSTS-MVBLE E	1,077,449		1,077,449				
006	EMPLOYEE BENEFITS	3,312,168	1,889		3,314,057			
007	ADMINISTRATIVE & GENERAL	4,693,872	58,668	397,594	511,561	5,661,695	5,661,695	
008	MAINTENANCE & REPAIRS	595,762	16,192	4,443	163,290	779,687	229,907	1,009,594
009	OPERATION OF PLANT	917,043	54,996	52,502	27,845	1,052,386	310,318	721,394
010	LAUNDRY & LINEN SERVICE	148,635	1,876	2,930	28,727	182,168	53,716	21,864
011	HOUSEKEEPING	356,005	6,851	1,665	83,178	447,699	132,013	2,106
012	DIETARY	320,370	13,092	4,087	44,883	382,432	112,768	10,158
013	CAFETERIA	363,963	5,031	6,840	75,125	450,959	132,975	16,971
014	NURSING ADMINISTRATION	354,993	4,517	34	96,653	456,197	134,519	4,274
015	CENTRAL SERVICES & SUPPLY	59,507	3,727	13,233	12,533	89,000	26,244	11,087
016	PHARMACY	422,215	2,559	55,122	112,086	591,982	174,558	2,168
017	MEDICAL RECORDS & LIBRARY	525,566	8,408	19,027	136,044	689,045	203,179	5,513
018	SOCIAL SERVICE	37,551	623		9,460	47,634	14,046	
025	INPAT ROUTINE SRVC CNTRS							
034	ADULTS & PEDIATRICS	1,881,263	30,433	29,895	511,900	2,453,491	723,468	97,677
037	SKILLED NURSING FACILITY	701,015	16,754	23,959	192,475	934,203	275,469	23,413
040	ANCILLARY SRVC COST CNTRS							
041	OPERATING ROOM	628,033	11,630	69,111	159,579	868,353	256,052	13,998
044	ANESTHESIOLOGY	55,496	1,435	48,014		104,945	30,945	2,849
049	RADIOLOGY-DIAGNOSTIC	1,864,256	14,822	244,284	280,092	2,403,454	708,709	11,830
050	LABORATORY	1,795,325	5,681	31,733	235,378	2,068,117	609,828	12,450
052	RESPIRATORY THERAPY	441,039	2,726	7,082	110,243	561,090	165,449	8,052
053	PHYSICAL THERAPY	662,115	8,706	5,769	181,623	858,213	253,062	8,486
055	01 PHYSICAL THERAPY - SNF	299,691				299,691	88,370	
056	SPEECH PATHOLOGY	88,752	652		6,861	96,265	28,386	62
057	ELECTROCARDIOLOGY	137,338	3,782	18,501	38,174	197,795	58,324	4,521
058	ELECTROENCEPHALOGRAPHY							
059	MEDICAL SUPPLIES CHARGED	476,793				476,793	140,592	
060	01 IMPLANTABLE DEVICES	127,961				127,961	37,732	
061	DRUGS CHARGED TO PATIENTS	924,378				924,378	272,572	
062	OUTPAT SERVICE COST CNTRS							
063	EMERGENCY	1,303,986	9,129	37,378	296,347	1,646,840	485,605	27,872
064	OBSERVATION BEDS (NON-DIS							
065	SPEC PURPOSE COST CENTERS							
066	SUBTOTALS	24,862,081	284,179	1,073,203	3,314,057	24,852,473	5,658,806	1,006,745
067	NONREIMBURS COST CENTERS							
068	GIFT, FLOWER, COFFEE SHOP		1,210			1,210	357	
069	PHYSICIANS' PRIVATE OFFIC	188	4,152	4,246		8,586	2,532	2,849
070	CROSS FOOT ADJUSTMENT							
071	NEGATIVE COST CENTER							
072	TOTAL	24,862,269	289,541	1,077,449	3,314,057	24,862,269	5,661,695	1,009,594

	COST CENTER DESCRIPTION	OPERATION OF PLANT	LAUNDRY & LIN EN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMIN ISTRATION	CENTRAL SERVI CES & SUPPLY
		8	9	10	11	12	14	15
003	GENERAL SERVICE COST CNTR							
004	NEW CAP REL COSTS-BLDG &							
005	NEW CAP REL COSTS-MVBLE E							
006	EMPLOYEE BENEFITS							
007	ADMINISTRATIVE & GENERAL							
008	MAINTENANCE & REPAIRS							
009	OPERATION OF PLANT	2,084,098						
010	LAUNDRY & LINEN SERVICE	24,780	282,528					
011	HOUSEKEEPING	90,484	8,318	680,620				
012	DIETARY	172,909	1,175	564	680,006			
013	CAFETERIA	66,446	1,986	7,335		676,672		
014	NURSING ADMINISTRATION	59,653				19,570	674,213	
015	CENTRAL SERVICES & SUPPLY	49,230	1,294	7,147		7,306		191,308
016	PHARMACY	33,801		7,523		20,518		14
017	MEDICAL RECORDS & LIBRARY	111,056		3,573		58,556		
018	SOCIAL SERVICE	8,223		4,702		2,986		
025	INPAT ROUTINE SRVC CNTRS							
034	ADULTS & PEDIATRICS	401,953	119,588	230,382	417,674	153,544	311,706	94,530
	SKILLED NURSING FACILITY	221,287	95,217	102,685	262,332	68,915	139,916	9,668
	ANCILLARY SRVC COST CNTRS							
037	OPERATING ROOM	153,602	16,451	75,039		36,848	74,802	10,007
040	ANESTHESIOLOGY	18,949						3,579
041	RADIOLOGY-DIAGNOSTIC	195,764	7,763	53,788		78,215		3,667
044	LABORATORY	75,027	739	31,031		73,245		177
049	RESPIRATORY THERAPY	36,001	555	12,789		30,766		22
050	PHYSICAL THERAPY	114,989	7,578	12,601		42,369		255
050	01 PHYSICAL THERAPY - SNF							
052	SPEECH PATHOLOGY	8,608		6,018		1,124		
053	ELECTROCARDIOLOGY	49,945				9,917		1,987
054	ELECTROENCEPHALOGRAPHY							
055	MEDICAL SUPPLIES CHARGED							
055	01 IMPLANTABLE DEVICES							
056	DRUGS CHARGED TO PATIENTS							
061	OUTPAT SERVICE COST CNTRS							
062	EMERGENCY	120,572	19,408	108,892		72,771	147,741	67,034
095	OBSERVATION BEDS (NON-DIS							
	SPEC PURPOSE COST CENTERS							
	SUBTOTALS	2,013,279	280,072	664,069	680,006	676,650	674,165	190,940
096	NONREIMBURS COST CENTERS							
098	GIFT, FLOWER, COFFEE SHOP	15,979		4,138				
101	PHYSICIANS' PRIVATE OFFIC	54,840	2,456	12,413		22	48	368
102	CROSS FOOT ADJUSTMENT							
103	NEGATIVE COST CENTER							
103	TOTAL	2,084,098	282,528	680,620	680,006	676,672	674,213	191,308

	COST CENTER DESCRIPTION	PHARMACY 16	MEDICAL RECOR DS & LIBRARY E 17	SOCIAL SERVIC E 18	SUBTOTAL 25	I&R COST POST STEP- DOWN ADJ 26	TOTAL 27
003	GENERAL SERVICE COST CNTR						
004	NEW CAP REL COSTS-BLDG &						
005	NEW CAP REL COSTS-MVBLE E						
006	EMPLOYEE BENEFITS						
007	ADMINISTRATIVE & GENERAL						
008	MAINTENANCE & REPAIRS						
009	OPERATION OF PLANT						
010	LAUNDRY & LINEN SERVICE						
011	HOUSEKEEPING						
012	DIETARY						
014	CAFETERIA						
015	NURSING ADMINISTRATION						
016	CENTRAL SERVICES & SUPPLY						
017	PHARMACY	830,564					
018	MEDICAL RECORDS & LIBRARY		1,070,922				
	SOCIAL SERVICE			77,591			
	INPAT ROUTINE SRVC CNTRS						
025	ADULTS & PEDIATRICS	342	327,840	61,343	5,393,538		5,393,538
034	SKILLED NURSING FACILITY	100	22,078	16,248	2,171,531		2,171,531
	ANCILLARY SRVC COST CNTRS						
037	OPERATING ROOM		64,116		1,569,268		1,569,268
040	ANESTHESIOLOGY	12			161,279		161,279
041	RADIOLOGY-DIAGNOSTIC	93,983	225,314		3,782,487		3,782,487
044	LABORATORY		66,838		2,937,452		2,937,452
049	RESPIRATORY THERAPY		13,912		828,636		828,636
050	PHYSICAL THERAPY		69,560		1,367,113		1,367,113
050 01	PHYSICAL THERAPY - SNF				388,061		388,061
052	SPEECH PATHOLOGY		4,234		144,697		144,697
053	ELECTROCARDIOLOGY		25,405		347,894		347,894
054	ELECTROENCEPHALOGRAPHY						
055	MEDICAL SUPPLIES CHARGED				617,385		617,385
055 01	IMPLANTABLE DEVICES				165,693		165,693
056	DRUGS CHARGED TO PATIENTS	734,878			1,931,828		1,931,828
	OUTPAT SERVICE COST CNTRS						
061	EMERGENCY	1,249	251,323		2,949,307		2,949,307
062	OBSERVATION BEDS (NON-DIS						
	SPEC PURPOSE COST CENTERS						
095	SUBTOTALS	830,564	1,070,620	77,591	24,756,169		24,756,169
	NONREIMBURS COST CENTERS						
096	GIFT, FLOWER, COFFEE SHOP				21,684		21,684
098	PHYSICIANS' PRIVATE OFFIC		302		84,416		84,416
101	CROSS FOOT ADJUSTMENT						
102	NEGATIVE COST CENTER						
103	TOTAL	830,564	1,070,922	77,591	24,862,269		24,862,269

ALLOCATION OF NEW CAPITAL RELATED COSTS

	COST CENTER DESCRIPTION	DIR ASSIGNED NEW CAPITAL REL COSTS 0	NEW CAP REL C OSTS-BLDG & 3	NEW CAP REL C OSTS-MVBLE E 4	SUBTOTAL 4a	EMPLOYEE BENE FITS 5	ADMINISTRATIV E & GENERAL 6	MAINTENANCE & REPAIRS 7
003	GENERAL SERVICE COST CNTR							
004	NEW CAP REL COSTS-BLDG &							
005	NEW CAP REL COSTS-MVBLE E							
005	EMPLOYEE BENEFITS		1,889		1,889	1,889		
006	ADMINISTRATIVE & GENERAL	65,540	58,668	397,594	521,802	292	522,094	
007	MAINTENANCE & REPAIRS		16,192	4,443	20,635	93	21,201	41,929
008	OPERATION OF PLANT		54,996	52,502	107,498	16	28,616	29,962
009	LAUNDRY & LINEN SERVICE		1,876	2,930	4,806	16	4,954	908
010	HOUSEKEEPING		6,851	1,665	8,516	47	12,174	87
011	DIETARY		13,092	4,087	17,179	26	10,399	422
012	CAFETERIA		5,031	6,840	11,871	43	12,262	705
014	NURSING ADMINISTRATION		4,517	34	4,551	55	12,405	177
015	CENTRAL SERVICES & SUPPLY		3,727	13,233	16,960	7	2,420	460
016	PHARMACY	8,820	2,559	55,122	66,501	64	16,097	90
017	MEDICAL RECORDS & LIBRARY		8,408	19,027	27,435	78	18,737	229
018	SOCIAL SERVICE		623		623	5	1,295	
025	INPAT ROUTINE SRVC CNTRS							
034	ADULTS & PEDIATRICS	4,370	30,433	29,895	64,698	290	66,707	4,057
034	SKILLED NURSING FACILITY	308	16,754	23,959	41,021	110	25,403	972
037	ANCILLARY SRVC COST CNTRS							
037	OPERATING ROOM		11,630	69,111	80,741	91	23,612	581
040	ANESTHESIOLOGY		1,435	48,014	49,449		2,854	118
041	RADIOLOGY-DIAGNOSTIC	111,816	14,822	244,284	370,922	160	65,355	491
044	LABORATORY		5,681	31,733	37,414	134	56,236	517
049	RESPIRATORY THERAPY	702	2,726	7,082	10,510	63	15,257	334
050	PHYSICAL THERAPY		8,706	5,769	14,475	104	23,337	352
050	01 PHYSICAL THERAPY - SNF						8,149	
052	SPEECH PATHOLOGY		652		652	4	2,618	3
053	ELECTROCARDIOLOGY		3,782	18,501	22,283	22	5,378	188
054	ELECTROENCEPHALOGRAPHY						12,965	
055	MEDICAL SUPPLIES CHARGED						3,480	
055	01 IMPLANTABLE DEVICES						25,136	
056	DRUGS CHARGED TO PATIENTS							
061	OUTPAT SERVICE COST CNTRS							
062	EMERGENCY		9,129	37,378	46,507	169	44,781	1,158
062	OBSERVATION BEDS (NON-DIS							
095	SPEC PURPOSE COST CENTERS							
095	SUBTOTALS	191,556	284,179	1,073,203	1,548,938	1,889	521,828	41,811
096	NONREIMBURS COST CENTERS							
096	GIFT, FLOWER, COFFEE SHOP		1,210		1,210		33	
098	PHYSICIANS' PRIVATE OFFIC		4,152	4,246	8,398		233	118
101	CROSS FOOT ADJUSTMENTS							
102	NEGATIVE COST CENTER							
103	TOTAL	191,556	289,541	1,077,449	1,558,546	1,889	522,094	41,929

ALLOCATION OF NEW CAPITAL RELATED COSTS

COST CENTER DESCRIPTION		OPERATION OF PLANT	LAUNDRY & LIN EN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY
		8	9	10	11	12	14	15
003	GENERAL SERVICE COST CNTR							
004	NEW CAP REL COSTS-BLDG &							
005	NEW CAP REL COSTS-MVBLE E							
006	EMPLOYEE BENEFITS							
007	ADMINISTRATIVE & GENERAL							
008	MAINTENANCE & REPAIRS							
009	OPERATION OF PLANT	166,092						
010	LAUNDRY & LINEN SERVICE	1,975	12,659					
011	HOUSEKEEPING	7,211	373	28,408				
012	DIETARY	13,780	53	24	41,883			
013	CAFETERIA	5,295	89	306		30,571		
014	NURSING ADMINISTRATION	4,754				884	22,826	
015	CENTRAL SERVICES & SUPPLY	3,923	58	298		330		24,456
016	PHARMACY	2,694		314		927		2
017	MEDICAL RECORDS & LIBRARY	8,851		149		2,645		
018	SOCIAL SERVICE	655		196		135		
025	INPAT ROUTINE SRVC CNTRS							
034	ADULTS & PEDIATRICS	32,037	5,357	9,616	25,725	6,937	10,553	12,084
	SKILLED NURSING FACILITY	17,635	4,266	4,286	16,158	3,113	4,737	1,236
	ANCILLARY SRVC COST CNTRS							
037	OPERATING ROOM	12,241	737	3,132		1,665	2,532	1,279
040	ANESTHESIOLOGY	1,510						457
041	RADIOLOGY-DIAGNOSTIC	15,601	348	2,245		3,534		469
044	LABORATORY	5,979	33	1,295		3,309		23
049	RESPIRATORY THERAPY	2,869	25	534		1,390		3
050	PHYSICAL THERAPY	9,164	340	526		1,914		33
050	01 PHYSICAL THERAPY - SNF							
052	SPEECH PATHOLOGY	686		251		51		
053	ELECTROCARDIOLOGY	3,980				448		254
054	ELECTROENCEPHALOGRAPHY							
055	MEDICAL SUPPLIES CHARGED							
055	01 IMPLANTABLE DEVICES							
056	DRUGS CHARGED TO PATIENTS							
061	OUTPAT SERVICE COST CNTRS							
062	EMERGENCY	9,609	870	4,545		3,288	5,002	8,569
095	OBSERVATION BEDS (NON-DIS							
	SPEC PURPOSE COST CENTERS							
	SUBTOTALS	160,449	12,549	27,717	41,883	30,570	22,824	24,409
096	NONREIMBURS COST CENTERS							
098	GIFT, FLOWER, COFFEE SHOP	1,273		173				
101	PHYSICIANS' PRIVATE OFFIC	4,370	110	518		1	2	47
102	CROSS FOOT ADJUSTMENTS							
103	NEGATIVE COST CENTER							
	TOTAL	166,092	12,659	28,408	41,883	30,571	22,826	24,456

ALLOCATION OF NEW CAPITAL RELATED COSTS

		PHARMACY	MEDICAL RECOR DS & LIBRARY	SOCIAL SERVICE	SUBTOTAL	POST STEPDOWN ADJUSTMENT	TOTAL
	COST CENTER DESCRIPTION	16	17	18	25	26	27
003	GENERAL SERVICE COST CNTR						
004	NEW CAP REL COSTS-BLDG &						
005	NEW CAP REL COSTS-MVBLE E						
006	EMPLOYEE BENEFITS						
007	ADMINISTRATIVE & GENERAL						
008	MAINTENANCE & REPAIRS						
009	OPERATION OF PLANT						
010	LAUNDRY & LINEN SERVICE						
011	HOUSEKEEPING						
012	DIETARY						
014	CAFETERIA						
015	NURSING ADMINISTRATION						
016	CENTRAL SERVICES & SUPPLY						
017	PHARMACY	86,689					
018	MEDICAL RECORDS & LIBRARY		58,124				
	SOCIAL SERVICE			2,909			
	INPAT ROUTINE SRVC CNTRS						
025	ADULTS & PEDIATRICS	36	17,793	2,300	258,190		258,190
034	SKILLED NURSING FACILITY	10	1,198	609	120,754		120,754
	ANCILLARY SRVC COST CNTRS						
037	OPERATING ROOM		3,480		130,091		130,091
040	ANESTHESIOLOGY	1			54,389		54,389
041	RADIOLOGY-DIAGNOSTIC	9,809	12,229		481,163		481,163
044	LABORATORY		3,628		108,568		108,568
049	RESPIRATORY THERAPY		755		31,740		31,740
050	PHYSICAL THERAPY		3,775		54,020		54,020
050 01	PHYSICAL THERAPY - SNF				8,149		8,149
052	SPEECH PATHOLOGY		230		4,495		4,495
053	ELECTROCARDIOLOGY		1,379		33,932		33,932
054	ELECTROENCEPHALOGRAPHY						
055	MEDICAL SUPPLIES CHARGED				12,965		12,965
055 01	IMPLANTABLE DEVICES				3,480		3,480
056	DRUGS CHARGED TO PATIENTS	76,703			101,839		101,839
	OUTPAT SERVICE COST CNTRS						
061	EMERGENCY	130	13,641		138,269		138,269
062	OBSERVATION BEDS (NON-DIS						
	SPEC PURPOSE COST CENTERS						
095	SUBTOTALS	86,689	58,108	2,909	1,542,044		1,542,044
	NONREIMBURS COST CENTERS						
096	GIFT, FLOWER, COFFEE SHOP				2,689		2,689
098	PHYSICIANS' PRIVATE OFFIC		16		13,813		13,813
101	CROSS FOOT ADJUSTMENTS						
102	NEGATIVE COST CENTER						
103	TOTAL	86,689	58,124	2,909	1,558,546		1,558,546

COST CENTER DESCRIPTION	NEW CAP REL C OSTS-BLDG &	NEW CAP REL C OSTS-MVBLE E	EMPLOYEE BENE FITS	S RECONCIL-) IATION	ADMINISTRATIV E & GENERAL	MAINTENANCE & REPAIRS	S)
	(SQUARE FEET	(DOLLAR)VALUE	(GROSS)ALARIES		(ACCUM. COST	(HOURS OF)SERVICE	
	3	4	5	6a.00	6	7	
003 GENERAL SERVICE COST	139,047						
004 NEW CAP REL COSTS-BLD		954,109					
005 EMPLOYEE BENEFITS	907		10,920,496				
006 ADMINISTRATIVE & GENE	28,175	352,080	1,685,700	-5,661,695	19,200,574		
007 MAINTENANCE & REPAIRS	7,776	3,934	538,075		779,687	16,300	
008 OPERATION OF PLANT	26,411	46,492	91,755		1,052,386	11,647	
009 LAUNDRY & LINEN SERVI	901	2,595	94,663		182,168	353	
010 HOUSEKEEPING	3,290	1,474	274,088		447,699	34	
011 DIETARY	6,287	3,619	147,898		382,432	164	
012 CAFETERIA	2,416	6,057	247,551		450,959	274	
014 NURSING ADMINISTRATIO	2,169	30	318,492		456,197	69	
015 CENTRAL SERVICES & SU	1,790	11,718	41,298		89,000	179	
016 PHARMACY	1,229	48,812	369,347		591,982	35	
017 MEDICAL RECORDS & LIB	4,038	16,849	448,294		689,045	89	
018 SOCIAL SERVICE	299		31,174		47,634		
025 INPAT ROUTINE SRVC CN	14,615	26,473	1,686,811		2,453,491	1,577	
034 ADULTS & PEDIATRICS	8,046	21,216	634,245		934,203	378	
037 ANCILLARY SRVC COST C	5,585	61,200	525,845		868,353	226	
040 OPERATING ROOM	689	42,518			104,945	46	
041 ANESTHESIOLOGY	7,118	216,320	922,962		2,403,454	191	
044 RADIOLOGY-DIAGNOSTIC	2,728	28,100	775,618		2,068,117	201	
049 LABORATORY	1,309	6,271	363,274		561,090	130	
050 RESPIRATORY THERAPY	4,181	5,109	598,484		858,213	137	
050 01 PHYSICAL THERAPY -					299,691		
052 SPEECH PATHOLOGY	313		22,607		96,265	1	
053 ELECTROCARDIOLOGY	1,816	16,383	125,791		197,795	73	
054 ELECTROENCEPHALOGRAPH					476,793		
055 MEDICAL SUPPLIES CHAR					127,961		
055 01 IMPLANTABLE DEVICES					924,378		
056 DRUGS CHARGED TO PATI							
061 OUTPAT SERVICE COST C	4,384	33,099	976,524		1,646,840	450	
062 EMERGENCY							
095 OBSERVATION BEDS (NON	136,472	950,349	10,920,496	-5,661,695	19,190,778	16,254	
096 SPEC PURPOSE COST CEN							
098 SUBTOTALS	581				1,210		
101 NONREIMBURS COST CENT	1,994	3,760			8,586	46	
102 GIFT, FLOWER, COFFEE							
103 PHYSICIANS' PRIVATE O							
104 CROSS FOOT ADJUSTMENT							
105 NEGATIVE COST CENTER	289,541	1,077,449	3,314,057		5,661,695	1,009,594	
106 COST TO BE ALLOCATED							
104 (WRKSHT B, PART I)	2.082325		.303471		.294871		
105 UNIT COST MULTIPLIER		1.129272				61.938282	
106 (WRKSHT B, PT I)							
107 COST TO BE ALLOCATED							
106 (WRKSHT B, PART II)							
107 UNIT COST MULTIPLIER			1,889		522,094	41,929	
108 (WRKSHT B, PT II)							
107 COST TO BE ALLOCATED							
108 (WRKSHT B, PART III)			.000173		.027192		
108 UNIT COST MULTIPLIER						2.572331	
108 (WRKSHT B, PT III)							

COST ALLOCATION - STATISTICAL BASIS

	COST CENTER DESCRIPTION	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	R
		(SQUARE FEET)	(POUNDS OF) LAUNDRY	(HOURS OF) SERVICE	(MEALS) SERVED	S(MEALS) SERVED	S(DIRECT)SING HRS	NR(COSTED)EQUIS.	
		8	9	10	11	12	14	15	
003	GENERAL SERVICE COST								
004	NEW CAP REL COSTS-BLD								
005	NEW CAP REL COSTS-MVB								
006	EMPLOYEE BENEFITS								
007	ADMINISTRATIVE & GENE								
008	MAINTENANCE & REPAIRS								
009	OPERATION OF PLANT	75,778							
010	LAUNDRY & LINEN SERVI	901	303,466						
011	HOUSEKEEPING	3,290	8,934	3,619					
012	DIETARY	6,287	1,262	3	36,692				
013	CAFETERIA	2,416	2,133	39		61,408			
014	NURSING ADMINISTRATIO	2,169				1,776	168,963		
015	CENTRAL SERVICES & SU	1,790	1,390	38		663		173,100	
016	PHARMACY	1,229		40		1,862		13	
017	MEDICAL RECORDS & LIB	4,038		19		5,314			
018	SOCIAL SERVICE	299		25		271			
025	INPAT ROUTINE SRVC CN								
034	ADULTS & PEDIATRICS	14,615	128,452	1,225	22,537	13,934	78,116	85,532	
037	SKILLED NURSING FACIL	8,046	102,273	546	14,155	6,254	35,064	8,748	
040	ANCILLARY SRVC COST C								
041	OPERATING ROOM	5,585	17,670	399		3,344	18,746	9,055	
044	ANESTHESIOLOGY	689						3,238	
049	RADIOLOGY-DIAGNOSTIC	7,118	8,338	286		7,098		3,318	
050	LABORATORY	2,728	794	165		6,647		160	
052	RESPIRATORY THERAPY	1,309	596	68		2,792		20	
053	PHYSICAL THERAPY	4,181	8,140	67		3,845		231	
054	01 PHYSICAL THERAPY -								
055	SPEECH PATHOLOGY	313		32		102			
056	ELECTROCARDIOLOGY	1,816				900		1,798	
061	ELECTROENCEPHALOGRAPH								
062	MEDICAL SUPPLIES CHAR								
066	01 IMPLANTABLE DEVICES								
067	DRUGS CHARGED TO PATI								
068	OUTPAT SERVICE COST C								
069	EMERGENCY	4,384	20,846	579		6,604	37,025	60,654	
070	OBSERVATION BEDS (NON								
071	SPEC PURPOSE COST CEN								
072	SUBTOTALS	73,203	300,828	3,531	36,692	61,406	168,951	172,767	
073	NONREIMBURS COST CENT								
074	GIFT, FLOWER, COFFEE	581		22					
075	PHYSICIANS' PRIVATE O	1,994	2,638	66		2	12	333	
076	CROSS FOOT ADJUSTMENT								
077	NEGATIVE COST CENTER								
078	COST TO BE ALLOCATED	2,084,098	282,528	680,620	680,006	676,672	674,213	191,308	
079	(WRKSHT B, PART I)								
080	UNIT COST MULTIPLIER		.931004		18.532814		3.990300	1.105188	
081	(WRKSHT B, PT I)	27.502679		188.068527		11.019281			
082	COST TO BE ALLOCATED								
083	(WRKSHT B, PART II)								
084	UNIT COST MULTIPLIER								
085	(WRKSHT B, PT II)								
086	COST TO BE ALLOCATED	166,092	12,659	28,408	41,883	30,571	22,826	24,456	
087	(WRKSHT B, PART III)								
088	UNIT COST MULTIPLIER		.041715		1.141475		.135095	.141282	
089	(WRKSHT B, PT III)	2.191823		7.849682		.497834			

COST ALLOCATION - STATISTICAL BASIS

COST CENTER DESCRIPTION		PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE
		(COSTED EQUIP.)	(TIME SPENT)	(TIME SPENT)
		16	17	18
003	GENERAL SERVICE COST			
004	NEW CAP REL COSTS-BLD			
005	NEW CAP REL COSTS-MVB			
006	EMPLOYEE BENEFITS			
007	ADMINISTRATIVE & GENE			
008	MAINTENANCE & REPAIRS			
009	OPERATION OF PLANT			
010	LAUNDRY & LINEN SERVI			
011	HOUSEKEEPING			
012	DIETARY			
014	CAFETERIA			
015	NURSING ADMINISTRATIO			
016	CENTRAL SERVICES & SU			
017	PHARMACY	3,352,427	3,541	
018	MEDICAL RECORDS & LIB			425
025	SOCIAL SERVICE			
034	INPAT ROUTINE SRVC CN			
	ADULTS & PEDIATRICS	1,380	1,084	336
	SKILLED NURSING FACIL	405	73	89
037	ANCILLARY SRVC COST C			
040	OPERATING ROOM		212	
041	ANESTHESIOLOGY	47		
044	RADIOLOGY-DIAGNOSTIC	379,345	745	
049	LABORATORY		221	
050	RESPIRATORY THERAPY	1	46	
050	PHYSICAL THERAPY		230	
052	01 PHYSICAL THERAPY -			
053	SPEECH PATHOLOGY		14	
054	ELECTROCARDIOLOGY		84	
055	ELECTROENCEPHALOGRAPH			
056	MEDICAL SUPPLIES CHAR			
	01 IMPLANTABLE DEVICES			
061	DRUGS CHARGED TO PATI	2,966,209		
062	OUTPAT SERVICE COST C			
095	EMERGENCY	5,040	831	
	OBSERVATION BEDS (NON			
	SPEC PURPOSE COST CEN			
	SUBTOTALS	3,352,427	3,540	425
096	NONREIMBURS COST CENT			
098	GIFT, FLOWER, COFFEE			
101	PHYSICIANS' PRIVATE O		1	
102	CROSS FOOT ADJUSTMENT			
103	NEGATIVE COST CENTER			
	COST TO BE ALLOCATED	830,564	1,070,922	77,591
104	(PER WRKSHT B, PART			
	UNIT COST MULTIPLIER		302.434905	
105	(WRKSHT B, PT I)	.247750		182.567059
106	COST TO BE ALLOCATED			
	(PER WRKSHT B, PART			
	UNIT COST MULTIPLIER			
107	(WRKSHT B, PT II)			
	COST TO BE ALLOCATED	86,689	58,124	2,909
108	(PER WRKSHT B, PART			
	UNIT COST MULTIPLIER		16.414572	
	(WRKSHT B, PT III)	.025859		6.844706

COMPUTATION OF RATIO OF COSTS TO CHARGES

WKST A LINE NO.	COST CENTER DESCRIPTION	INPATIENT CHARGES 6	OUTPATIENT CHARGES 7	TOTAL CHARGES 8	COST OR OTHER RATIO 9	TEFRA INPAT- IENT RATIO 10	PPS INPAT- IENT RATIO 11
25	INPAT ROUTINE SRVC CNTRS						
34	ADULTS & PEDIATRICS	5,993,777		5,993,777			
	SKILLED NURSING FACILITY	1,115,597		1,115,597			
	ANCILLARY SRVC COST CNTRS						
37	OPERATING ROOM	600,088	1,777,960	2,378,048	.659898	.659898	.659898
40	ANESTHESIOLOGY	20,103	139,889	159,992	1.008044	1.008044	1.008044
41	RADIOLOGY-DIAGNOSTIC	2,018,856	16,817,092	18,835,948	.200812	.200812	.200812
44	LABORATORY	1,907,483	6,763,712	8,671,195	.338760	.338760	.338760
49	RESPIRATORY THERAPY	289,772	1,538,046	1,827,818	.453347	.453347	.453347
50	PHYSICAL THERAPY	266,460	2,133,302	2,399,762	.569687	.569687	.569687
50	01 PHYSICAL THERAPY - SNF	1,445,544		1,445,544	.268453	.268453	.268453
52	SPEECH PATHOLOGY	59,015	292,063	351,078	.412151	.412151	.412151
53	ELECTROCARDIOLOGY	378,973	1,191,864	1,570,837	.221470	.221470	.221470
54	ELECTROENCEPHALOGRAPHY						
55	MEDICAL SUPPLIES CHARGED	2,305,173	1,607,074	3,912,247	.157808	.157808	.157808
55	01 IMPLANTABLE DEVICES	8,999	151,278	160,277	1.033791	1.033791	1.033791
56	DRUGS CHARGED TO PATIENTS	1,495,579	1,445,853	2,941,432	.656764	.656764	.656764
	OUTPAT SERVICE COST CNTRS						
61	EMERGENCY	125,244	4,656,549	4,781,793	.616778	.616778	.616778
62	OBSERVATION BEDS (NON-DIS	100	233,100	233,200	1.112363	1.112363	1.112363
	OTHER REIMBURS COST CNTRS						
101	SUBTOTAL	18,030,763	38,747,782	56,778,545			
102	LESS OBSERVATION BEDS						
103	TOTAL	18,030,763	38,747,782	56,778,545			

WKST A LINE NO.	COST CENTER DESCRIPTION	WKST B, PT I COL. 27 1	THERAPY ADJUSTMENT 2	TOTAL COSTS 3	RCE DISALLOWANCE 4	TOTAL COSTS 5
	INPAT ROUTINE SRVC CNTRS					
25	ADULTS & PEDIATRICS	5,393,538		5,393,538		5,393,538
34	SKILLED NURSING FACILITY	2,171,531		2,171,531		2,171,531
	ANCILLARY SRVC COST CNTRS					
37	OPERATING ROOM	1,569,268		1,569,268		1,569,268
40	ANESTHESIOLOGY	161,279		161,279		161,279
41	RADIOLOGY-DIAGNOSTIC	3,782,487		3,782,487		3,782,487
44	LABORATORY	2,937,452		2,937,452		2,937,452
49	RESPIRATORY THERAPY	828,636		828,636		828,636
50	PHYSICAL THERAPY	1,367,113		1,367,113		1,367,113
50 01	PHYSICAL THERAPY - SNF	388,061		388,061		388,061
52	SPEECH PATHOLOGY	144,697		144,697		144,697
53	ELECTROCARDIOLOGY	347,894		347,894		347,894
54	ELECTROENCEPHALOGRAPHY					
55	MEDICAL SUPPLIES CHARGED	617,385		617,385		617,385
55 01	IMPLANTABLE DEVICES	165,693		165,693		165,693
56	DRUGS CHARGED TO PATIENTS	1,931,828		1,931,828		1,931,828
	OUTPAT SERVICE COST CNTRS					
61	EMERGENCY	2,949,307		2,949,307		2,949,307
62	OBSERVATION BEDS (NON-DIS	259,403		259,403		259,403
	OTHER REIMBURS COST CNTRS					
101	SUBTOTAL	25,015,572		25,015,572		25,015,572
102	LESS OBSERVATION BEDS	259,403		259,403		259,403
103	TOTAL	24,756,169		24,756,169		24,756,169

WKST A LINE NO.	COST CENTER DESCRIPTION	INPATIENT CHARGES 6	OUTPATIENT CHARGES 7	TOTAL CHARGES 8	COST OR OTHER RATIO 9	TEFRA INPAT- IENT RATIO 10	PPS INPAT- IENT RATIO 11
25	INPAT ROUTINE SRVC CNTRS						
34	ADULTS & PEDIATRICS	5,993,777		5,993,777			
	SKILLED NURSING FACILITY	1,115,597		1,115,597			
	ANCILLARY SRVC COST CNTRS						
37	OPERATING ROOM	600,088	1,777,960	2,378,048	.659898	.659898	.659898
40	ANESTHESIOLOGY	20,103	139,889	159,992	1.008044	1.008044	1.008044
41	RADIOLOGY-DIAGNOSTIC	2,018,856	16,817,092	18,835,948	.200812	.200812	.200812
44	LABORATORY	1,907,483	6,763,712	8,671,195	.338760	.338760	.338760
49	RESPIRATORY THERAPY	289,772	1,538,046	1,827,818	.453347	.453347	.453347
50	PHYSICAL THERAPY	266,460	2,133,302	2,399,762	.569687	.569687	.569687
50	01 PHYSICAL THERAPY - SNF	1,445,544		1,445,544	.268453	.268453	.268453
52	SPEECH PATHOLOGY	59,015	292,063	351,078	.412151	.412151	.412151
53	ELECTROCARDIOLOGY	378,973	1,191,864	1,570,837	.221470	.221470	.221470
54	ELECTROENCEPHALOGRAPHY						
55	MEDICAL SUPPLIES CHARGED	2,305,173	1,607,074	3,912,247	.157808	.157808	.157808
55	01 IMPLANTABLE DEVICES	8,999	151,278	160,277	1.033791	1.033791	1.033791
56	DRUGS CHARGED TO PATIENTS	1,495,579	1,445,853	2,941,432	.656764	.656764	.656764
	OUTPAT SERVICE COST CNTRS						
61	EMERGENCY	125,244	4,656,549	4,781,793	.616778	.616778	.616778
62	OBSERVATION BEDS (NON-DIS	100	233,100	233,200	1.112363	1.112363	1.112363
	OTHER REIMBURS COST CNTRS						
101	SUBTOTAL	18,030,763	38,747,782	56,778,545			
102	LESS OBSERVATION BEDS						
103	TOTAL	18,030,763	38,747,782	56,778,545			

WKST A LINE NO.	COST CENTER DESCRIPTION	TOTAL COST WKST B, PT I COL. 27 1	CAPITAL COST WKST B PT II & III, COL. 27 2	OPERATING COST NET OF CAPITAL COST 3	CAPITAL REDUCTION 4	OPERATING COST REDUCTION AMOUNT 5	COST NET OF CAP AND OPER COST REDUCTION 6
37	ANCILLARY SRVC COST CNTRS	1,569,268	130,091	1,439,177			1,569,268
40	OPERATING ROOM	161,279	54,389	106,890			161,279
41	ANESTHESIOLOGY	3,782,487	481,163	3,301,324			3,782,487
44	RADIOLOGY-DIAGNOSTIC	2,937,452	108,568	2,828,884			2,937,452
49	LABORATORY	828,636	31,740	796,896			828,636
50	RESPIRATORY THERAPY	1,367,113	54,020	1,313,093			1,367,113
50	01 PHYSICAL THERAPY - SNF	388,061	8,149	379,912			388,061
52	SPEECH PATHOLOGY	144,697	4,495	140,202			144,697
53	ELECTROCARDIOLOGY	347,894	33,932	313,962			347,894
54	ELECTROENCEPHALOGRAPHY						617,385
55	MEDICAL SUPPLIES CHARGED	617,385	12,965	604,420			165,693
55	01 IMPLANTABLE DEVICES	165,693	3,480	162,213			1,931,828
56	DRUGS CHARGED TO PATIENTS	1,931,828	101,839	1,829,989			
61	OUTPAT SERVICE COST CNTRS						2,949,307
62	EMERGENCY	2,949,307	138,269	2,811,038			259,403
62	OBSERVATION BEDS (NON-DIS	259,403		259,403			
101	OTHER REIMBURS COST CNTRS						17,450,503
102	SUBTOTAL	17,450,503	1,163,100	16,287,403			259,403
102	LESS OBSERVATION BEDS	259,403		259,403			17,191,100
103	TOTAL	17,191,100	1,163,100	16,028,000			

WKST A	COST CENTER DESCRIPTION	TOTAL CHARGES	OUTPAT COST TO CHRG RATIO	I/P PT B COST TO CHRG RATIO
LINE NO.		7	8	9
37	ANCILLARY SRVC COST CNTRS			
	OPERATING ROOM	2,378,048	.659898	.659898
40	ANESTHESIOLOGY	159,992	1.008044	1.008044
41	RADIOLOGY-DIAGNOSTIC	18,835,948	.200812	.200812
44	LABORATORY	8,671,195	.338760	.338760
49	RESPIRATORY THERAPY	1,827,818	.453347	.453347
50	PHYSICAL THERAPY	2,399,762	.569687	.569687
50 01	PHYSICAL THERAPY - SNF	1,445,544	.268453	.268453
52	SPEECH PATHOLOGY	351,078	.412151	.412151
53	ELECTROCARDIOLOGY	1,570,837	.221470	.221470
54	ELECTROENCEPHALOGRAPHY			
55	MEDICAL SUPPLIES CHARGED	3,912,247	.157808	.157808
55 01	IMPLANTABLE DEVICES	160,277	1.033791	1.033791
56	DRUGS CHARGED TO PATIENTS	2,941,432	.656764	.656764
	OUTPAT SERVICE COST CNTRS			
61	EMERGENCY	4,781,793	.616778	.616778
62	OBSERVATION BEDS (NON-DIS	233,200	1.112363	1.112363
	OTHER REIMBURS COST CNTRS			
101	SUBTOTAL	49,669,171		
102	LESS OBSERVATION BEDS	233,200		
103	TOTAL	49,435,971		

WKST A LINE NO.	COST CENTER DESCRIPTION	TOTAL COST WKST B, PT I COL. 27 1	CAPITAL COST WKST B PT II & III, COL. 27 2	OPERATING COST NET OF CAPITAL COST 3	CAPITAL REDUCTION 4	OPERATING COST REDUCTION AMOUNT 5	COST NET OF CAP AND OPER COST REDUCTION 6
37	ANCILLARY SRVC COST CNTRS						1,569,268
40	OPERATING ROOM	1,569,268	130,091	1,439,177			161,279
41	ANESTHESIOLOGY	161,279	54,389	106,890			3,782,487
44	RADIOLOGY-DIAGNOSTIC	3,782,487	481,163	3,301,324			2,937,452
49	LABORATORY	2,937,452	108,568	2,828,884			828,636
50	RESPIRATORY THERAPY	828,636	31,740	796,896			1,367,113
50	PHYSICAL THERAPY	1,367,113	54,020	1,313,093			388,061
50	01 PHYSICAL THERAPY - SNF	388,061	8,149	379,912			144,697
52	SPEECH PATHOLOGY	144,697	4,495	140,202			347,894
53	ELECTROCARDIOLOGY	347,894	33,932	313,962			
54	ELECTROENCEPHALOGRAPHY						617,385
55	MEDICAL SUPPLIES CHARGED	617,385	12,965	604,420			165,693
55	01 IMPLANTABLE DEVICES	165,693	3,480	162,213			1,931,828
56	DRUGS CHARGED TO PATIENTS	1,931,828	101,839	1,829,989			2,949,307
61	OUTPAT SERVICE COST CNTRS						259,403
61	EMERGENCY	2,949,307	138,269	2,811,038			
62	OBSERVATION BEDS (NON-DIS	259,403		259,403			17,450,503
	OTHER REIMBURS COST CNTRS						259,403
101	SUBTOTAL	17,450,503	1,163,100	16,287,403			17,191,100
102	LESS OBSERVATION BEDS	259,403		259,403			
103	TOTAL	17,191,100	1,163,100	16,028,000			

WKST A	COST CENTER DESCRIPTION	TOTAL CHARGES	OUTPAT COST TO CHRG RATIO	I/P PT B COST TO CHRG RATIO
LINE NO.		7	8	9
	ANCILLARY SRVC COST CNTRS			
37	OPERATING ROOM	2,378,048	.659898	.659898
40	ANESTHESIOLOGY	159,992	1.008044	1.008044
41	RADIOLOGY-DIAGNOSTIC	18,835,948	.200812	.200812
44	LABORATORY	8,671,195	.338760	.338760
49	RESPIRATORY THERAPY	1,827,818	.453347	.453347
50	PHYSICAL THERAPY	2,399,762	.569687	.569687
50	01 PHYSICAL THERAPY - SNF	1,445,544	.268453	.268453
52	SPEECH PATHOLOGY	351,078	.412151	.412151
53	ELECTROCARDIOLOGY	1,570,837	.221470	.221470
54	ELECTROENCEPHALOGRAPHY			
55	MEDICAL SUPPLIES CHARGED	3,912,247	.157808	.157808
55	01 IMPLANTABLE DEVICES	160,277	1.033791	1.033791
56	DRUGS CHARGED TO PATIENTS	2,941,432	.656764	.656764
	OUTPAT SERVICE COST CNTRS			
61	EMERGENCY	4,781,793	.616778	.616778
62	OBSERVATION BEDS (NON-DIS	233,200	1.112363	1.112363
	OTHER REIMBURS COST CNTRS			
101	SUBTOTAL	49,669,171		
102	LESS OBSERVATION BEDS	233,200		
103	TOTAL	49,435,971		

TITLE XVIII, PART B

HOSPITAL

		Cost/Charge Ratio (C, Pt I, col. 9)	Cost/Charge Ratio (C, Pt I, col. 9)	Cost/Charge Ratio (C, Pt II, col. 9)	Outpatient Ambulatory Surgical Ctr	Outpatient Radiology
Cost Center Description		1	1.01	1.02	2	3
(A)	ANCILLARY SRVC COST CNTRS			.659898		
37	OPERATING ROOM			1.008044		
40	ANESTHESIOLOGY			.200812		
41	RADIOLOGY-DIAGNOSTIC			.338760		
44	LABORATORY			.453347		
49	RESPIRATORY THERAPY			.569687		
50	PHYSICAL THERAPY			.268453		
50 01	PHYSICAL THERAPY - SNF			.412151		
52	SPEECH PATHOLOGY			.221470		
53	ELECTROCARDIOLOGY					
54	ELECTROENCEPHALOGRAPHY			.157808		
55	MEDICAL SUPPLIES CHARGED TO PATIENTS			1.033791		
55 01	IMPLANTABLE DEVICES			.656764		
56	DRUGS CHARGED TO PATIENTS					
	OUTPAT SERVICE COST CNTRS			.616778		
61	EMERGENCY			1.112363		
62	OBSERVATION BEDS (NON-DISTINCT PART)					
101	SUBTOTAL					
102	CRNA CHARGES					
103	LESS PBP CLINIC LAB SVCS-					
	PROGRAM ONLY CHARGES					
104	NET CHARGES					

TITLE XVIII, PART B

HOSPITAL

		other Outpatient Diagnostic	All other (1)	Outpatient Ambulatory Surgical Ctr	Outpatient Radiology	other Outpatient Diagnostic
Cost Center Description		4	5	6	7	8
(A)	ANCILLARY SRVC COST CNTRS		744,369			
37	OPERATING ROOM		49,486			
40	ANESTHESIOLOGY		6,569,246			
41	RADIOLOGY-DIAGNOSTIC		2,767,314			
44	LABORATORY		733,381			
49	RESPIRATORY THERAPY		711,951			
50	PHYSICAL THERAPY					
50 01	PHYSICAL THERAPY - SNF		31,027			
52	SPEECH PATHOLOGY		676,334			
53	ELECTROCARDIOLOGY					
54	ELECTROENCEPHALOGRAPHY		675,004			
55	MEDICAL SUPPLIES CHARGED TO PATIENTS		116,610			
55 01	IMPLANTABLE DEVICES		721,793			
56	DRUGS CHARGED TO PATIENTS					
	OUTPAT SERVICE COST CNTRS					
61	EMERGENCY		1,632,888			
62	OBSERVATION BEDS (NON-DISTINCT PART)		101,666			
101	SUBTOTAL		15,531,069			
102	CRNA CHARGES					
103	LESS PBP CLINIC LAB SVCS-					
	PROGRAM ONLY CHARGES					
104	NET CHARGES		15,531,069			

TITLE XVIII, PART B

HOSPITAL

All other

Hospital I/P
Part B Charges

Hospital I/P
Part B Costs

Cost Center Description

9

10

11

(A)	ANCILLARY SRVC COST CNTRS			
37	OPERATING ROOM	491,208		
40	ANESTHESIOLOGY	49,884		
41	RADIOLOGY-DIAGNOSTIC	1,319,183		
44	LABORATORY	937,455		
49	RESPIRATORY THERAPY	332,476		
50	PHYSICAL THERAPY	405,589		
50	01 PHYSICAL THERAPY - SNF			
52	SPEECH PATHOLOGY	12,788		
53	ELECTROCARDIOLOGY	149,788		
54	ELECTROENCEPHALOGRAPHY			
55	MEDICAL SUPPLIES CHARGED TO PATIENTS	106,521		
55	01 IMPLANTABLE DEVICES	120,550		
56	DRUGS CHARGED TO PATIENTS	474,048		
	OUTPAT SERVICE COST CNTRS			
61	EMERGENCY	1,007,129		
62	OBSERVATION BEDS (NON-DISTINCT PART)	113,089		
101	SUBTOTAL	5,519,708		
102	CRNA CHARGES			
103	LESS PBP CLINIC LAB SVCS-			
	PROGRAM ONLY CHARGES			
104	NET CHARGES	5,519,708		

TITLE XVIII, PART B HOSPITAL

PART VI - VACCINE COST APPORTIONMENT

1	DRUGS CHARGED TO PATIENTS-RATIO OF COST TO CHARGES	1	.656764
2	PROGRAM VACCINE CHARGES		2,584
3	PROGRAM COSTS		1,697

TITLE XVIII, PART A		SKILLED NURSING FACILITY			PPS		
WKST A	COST CENTER DESCRIPTION	OLD CAPITAL	NEW CAPITAL	TOTAL	INPAT PROGRAM	OLD CAPITAL	
LINE NO.		RELATED COST	RELATED COST	CHARGES	CHARGES	CST/CHRG RATIO	COSTS
		1	2	3	4	5	6
	ANCILLARY SRVC COST CNTRS						
37	OPERATING ROOM						
40	ANESTHESIOLOGY						
41	RADIOLOGY-DIAGNOSTIC						
44	LABORATORY						
49	RESPIRATORY THERAPY						
50	PHYSICAL THERAPY						
50	01 PHYSICAL THERAPY - SNF						
52	SPEECH PATHOLOGY						
53	ELECTROCARDIOLOGY						
54	ELECTROENCEPHALOGRAPHY						
55	MEDICAL SUPPLIES CHARGED						
55	01 IMPLANTABLE DEVICES						
56	DRUGS CHARGED TO PATIENTS						
	OUTPAT SERVICE COST CNTRS						
61	EMERGENCY						
62	OBSERVATION BEDS (NON-DIS						
	OTHER REIMBURS COST CNTRS						
101	TOTAL						

TITLE XVIII, PART A	SKILLED NURSING FACILITY	PPS
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WKST A	COST CENTER DESCRIPTION	NEW CAPITAL	
LINE NO.		CST/CHRG RATIO	COSTS
		7	8
	ANCILLARY SRVC COST CNTRS		
37	OPERATING ROOM		
40	ANESTHESIOLOGY		
41	RADIOLOGY-DIAGNOSTIC		
44	LABORATORY		
49	RESPIRATORY THERAPY		
50	PHYSICAL THERAPY		
50	01 PHYSICAL THERAPY - SNF		
52	SPEECH PATHOLOGY		
53	ELECTROCARDIOLOGY		
54	ELECTROENCEPHALOGRAPHY		
55	MEDICAL SUPPLIES CHARGED		
55	01 IMPLANTABLE DEVICES		
56	DRUGS CHARGED TO PATIENTS		
	OUTPAT SERVICE COST CNTRS		
61	EMERGENCY		
62	OBSERVATION BEDS (NON-DIS		
	OTHER REIMBURS COST CNTRS		
101	TOTAL		

TITLE XVIII, PART A

SKILLED NURSING FACILITY

PPS

WKST A	COST CENTER DESCRIPTION	NONPHYSICIAN	MED ED NRS	MED ED ALLIED	MED ED ALL	BLOOD CLOT FOR
LINE NO.		ANESTHETIST	SCHOOL COST	HEALTH COST	OTHER COSTS	HEMOPHILIACS
		1	2	2.01	2.02	2.03
	ANCILLARY SRVC COST CNTRS					
37	OPERATING ROOM					
40	ANESTHESIOLOGY					
41	RADIOLOGY-DIAGNOSTIC					
44	LABORATORY					
49	RESPIRATORY THERAPY					
50	PHYSICAL THERAPY					
50	01 PHYSICAL THERAPY - SNF					
52	SPEECH PATHOLOGY					
53	ELECTROCARDIOLOGY					
54	ELECTROENCEPHALOGRAPHY					
55	MEDICAL SUPPLIES CHARGED					
55	01 IMPLANTABLE DEVICES					
56	DRUGS CHARGED TO PATIENTS					
	OUTPAT SERVICE COST CNTRS					
61	EMERGENCY					
62	OBSERVATION BEDS (NON-DIS					
	OTHER REIMBURS COST CNTRS					
101	TOTAL					

TITLE XVIII, PART A

SKILLED NURSING FACILITY

PPS

WKST A	COST CENTER DESCRIPTION	TOTAL COSTS	O/P PASS THRU COSTS	TOTAL CHARGES	RATIO OF COST TO CHARGES	O/P RATIO OF COST TO CHARGES	INPAT PROG CHARGE	INPAT PROG PASS THRU COST
LINE NO.		3	3.01	4	5	5.01	6	7
	ANCILLARY SRVC COST CNTRS			2,378,048			4,849	
37	OPERATING ROOM			159,992			280	
40	ANESTHESIOLOGY			18,835,948			117,683	
41	RADIOLOGY-DIAGNOSTIC			8,671,195			197,674	
44	LABORATORY			1,827,818			11,221	
49	RESPIRATORY THERAPY			2,399,762				
50	PHYSICAL THERAPY			1,445,544			1,292,890	
50 01	PHYSICAL THERAPY - SNF			351,078				
52	SPEECH PATHOLOGY			1,570,837			5,409	
53	ELECTROCARDIOLOGY							
54	ELECTROENCEPHALOGRAPHY			3,912,247			289,385	
55	MEDICAL SUPPLIES CHARGED			160,277				
55 01	IMPLANTABLE DEVICES			2,941,432			267,785	
56	DRUGS CHARGED TO PATIENTS							
	OUTPAT SERVICE COST CNTRS			4,781,793				
61	EMERGENCY			233,200				
62	OBSERVATION BEDS (NON-DIS							
	OTHER REIMBURS COST CNTRS							
101	TOTAL			49,669,171			2,187,176	

TITLE XVIII, PART A

SKILLED NURSING FACILITY

PPS

WKST A	COST CENTER DESCRIPTION	OUTPAT PROG	OUTPAT PROG	OUTPAT PROG	OUTPAT PROG	COL 8.01	COL 8.02
LINE NO.		CHARGES	D,V COL 5.03	D,V COL 5.04	PASS THRU COST	* COL 5	* COL 5
		8	8.01	8.02	9	9.01	9.02
37	ANCILLARY SRVC COST CNTRS						
40	OPERATING ROOM						
41	ANESTHESIOLOGY						
44	RADIOLOGY-DIAGNOSTIC						
49	LABORATORY						
50	RESPIRATORY THERAPY						
50	PHYSICAL THERAPY						
50	01 PHYSICAL THERAPY - SNF						
52	SPEECH PATHOLOGY						
53	ELECTROCARDIOLOGY						
54	ELECTROENCEPHALOGRAPHY						
55	MEDICAL SUPPLIES CHARGED						
55	01 IMPLANTABLE DEVICES						
56	DRUGS CHARGED TO PATIENTS						
61	OUTPAT SERVICE COST CNTRS						
62	EMERGENCY						
	OBSERVATION BEDS (NON-DIS						
	OTHER REIMBURS COST CNTRS						
101	TOTAL						

TITLE XVIII PART A

HOSPITAL

OTHER

PART I - ALL PROVIDER COMPONENTS

1

INPATIENT DAYS

1	INPATIENT DAYS (INCLUDING PRIVATE ROOM AND SWING BED DAYS, EXCLUDING NEWBORN)	5,892
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM, EXCLUDING SWING-BED AND NEWBORN DAYS)	5,557
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	5,557
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS)	82
6	THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER	244
	DECEMBER 31 OF COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
7	TOTAL SWING-BED NF TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS)	1
	THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
8	TOTAL SWING-BED NF TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER	8
	DECEMBER 31 OF COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
9	TOTAL INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM	4,055
	(EXCLUDING SWING-BED AND NEWBORN DAYS)	
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING	82
	PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
11	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING	244
	PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR	
	YEAR, ENTER 0 ON THIS LINE)	
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V & XIX ONLY (INCLUDING	
	PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLE V & XIX ONLY (INCLUDING	
	PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR	
	YEAR, ENTER 0 ON THIS LINE)	
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM	
	(EXCLUDING SWING-BED DAYS)	
15	TOTAL NURSERY DAYS (TITLE V OR XIX ONLY)	
16	NURSERY DAYS (TITLE V OR XIX ONLY)	

SWING-BED ADJUSTMENT

17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH	
	DECEMBER 31 OF THE COST REPORTING PERIOD	
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER	
	DECEMBER 31 OF THE COST REPORTING PERIOD	
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH	116.26
	DECEMBER 31 OF THE COST REPORTING PERIOD	
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER	116.26
	DECEMBER 31 OF THE COST REPORTING PERIOD	
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST	5,393,538
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST	
	REPORTING PERIOD	
23	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST	
	REPORTING PERIOD	
24	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST	116
	REPORTING PERIOD	
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST	930
	REPORTING PERIOD	
26	TOTAL SWING-BED COST (SEE INSTRUCTIONS)	299,864
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	5,093,674

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	5,821,109
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	5,821,109
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO	.875035
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE	
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE	1,047.53
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL	
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL	
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT	
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM	5,093,674
	COST DIFFERENTIAL	

TITLE XVIII PART A

HOSPITAL

OTHER

PART II - HOSPITAL AND SUBPROVIDERS ONLY

1

PROGRAM INPATIENT OPERATING COST BEFORE
PASS THROUGH COST ADJUSTMENTS

38 ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM 916.62
 39 PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST 3,716,894
 40 MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM
 41 TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST 3,716,894

	TOTAL I/P COST 1	TOTAL I/P DAYS 2	AVERAGE PER DIEM 3	PROGRAM DAYS 4	PROGRAM COST 5
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42	NURSERY (TITLE V & XIX ONLY)				
	INTENSIVE CARE TYPE INPATIENT				
	HOSPITAL UNITS				
43	INTENSIVE CARE UNIT				
44	CORONARY CARE UNIT				
45	BURN INTENSIVE CARE UNIT				
46	SURGICAL INTENSIVE CARE UNIT				
47	OTHER SPECIAL CARE				1
					2,000,003
48	PROGRAM INPATIENT ANCILLARY SERVICE COST				5,716,897
49	TOTAL PROGRAM INPATIENT COSTS				

PASS THROUGH COST ADJUSTMENTS

50 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES
 51 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES
 52 TOTAL PROGRAM EXCLUDABLE COST
 53 TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN
 ANESTHETIST, AND MEDICAL EDUCATION COSTS

TARGET AMOUNT AND LIMIT COMPUTATION

54 PROGRAM DISCHARGES
 55 TARGET AMOUNT PER DISCHARGE
 56 TARGET AMOUNT
 57 DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMOUNT
 58 BONUS PAYMENT
 58.01 LESSER OF LINES 53/54 OR 55 FROM THE COST REPORTING PERIOD ENDING 1996, UPDATED
 AND COMPOUNDED BY THE MARKET BASKET
 58.02 LESSER OF LINES 53/54 OR 55 FROM PRIOR YEAR COST REPORT, UPDATED BY THE MARKET
 BASKET
 58.03 IF LINES 53/54 IS LESS THAN THE LOWER OF LINES 55, 58.01 OR 58.02 ENTER THE
 LESSER OF 50% OF THE AMOUNT BY WHICH OPERATING COSTS (LINE 53) ARE LESS THAN
 EXPECTED COSTS (LINES 54 x 58.02), OR 1 PERCENT OF THE TARGET AMOUNT (LINE 56)
 OTHERWISE ENTER ZERO.
 58.04 RELIEF PAYMENT
 59 ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT
 59.01 ALLOWABLE INPATIENT COST PER DISCHARGE (LINE 59 / LINE 54) (LTCH ONLY)
 59.02 PROGRAM DISCHARGES PRIOR TO JULY 1
 59.03 PROGRAM DISCHARGES AFTER JULY 1
 59.04 PROGRAM DISCHARGES (SEE INSTRUCTIONS)
 59.05 REDUCED INPATIENT COST PER DISCHARGE FOR DISCHARGES PRIOR TO JULY 1
 (SEE INSTRUCTIONS) (LTCH ONLY)
 59.06 REDUCED INPATIENT COST PER DISCHARGE FOR DISCHARGES AFTER JULY 1
 (SEE INSTRUCTIONS) (LTCH ONLY)
 59.07 REDUCED INPATIENT COST PER DISCHARGE (SEE INSTRUCTIONS) (LTCH ONLY)
 59.08 REDUCED INPATIENT COST PLUS INCENTIVE PAYMENT (SEE INSTRUCTIONS)

PROGRAM INPATIENT ROUTINE SWING BED COST

60	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS)	75,163
61	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS)	223,655
62	TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS	298,818
63	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
64	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
65	TOTAL TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS	

TITLE XVIII PART A HOSPITAL OTHER

PART III - SKILLED NURSING FACILITY, NURSING FACILITY & ICF/MR ONLY

1

66 SKILLED NURSING FACILITY/OTHER NURSING FACILITY/ICF/MR ROUTINE
 SERVICE COST
 67 ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM
 68 PROGRAM ROUTINE SERVICE COST
 69 MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO PROGRAM
 70 TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COSTS
 71 CAPITAL-RELATED COST ALLOCATED TO INPATIENT ROUTINE SERVICE COSTS
 72 PER DIEM CAPITAL-RELATED COSTS
 73 PROGRAM CAPITAL-RELATED COSTS
 74 INPATIENT ROUTINE SERVICE COST
 75 AGGREGATE CHARGES TO BENEFICIARIES FOR EXCESS COSTS
 76 TOTAL PROGRAM ROUTINE SERVICE COSTS FOR COMPARISON TO THE COST LIMITATION
 77 INPATIENT ROUTINE SERVICE COST PER DIEM LIMITATION
 78 INPATIENT ROUTINE SERVICE COST LIMITATION
 79 REASONABLE INPATIENT ROUTINE SERVICE COSTS
 80 PROGRAM INPATIENT ANCILLARY SERVICES
 81 UTILIZATION REVIEW - PHYSICIAN COMPENSATION
 82 TOTAL PROGRAM INPATIENT OPERATING COSTS

PART IV - COMPUTATION OF OBSERVATION BED COST

83 TOTAL OBSERVATION BED DAYS 283
 84 ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM 916.62
 85 OBSERVATION BED COST 259,403

COMPUTATION OF OBSERVATION BED PASS THROUGH COST

	COST	ROUTINE COST	COLUMN 1 DIVIDED BY COLUMN 2	TOTAL OBSERVATION BED COST	OBSERVATION BED PASS THROUGH COST
	1	2	3	4	5
86 OLD CAPITAL-RELATED COST					
87 NEW CAPITAL-RELATED COST					
88 NON PHYSICIAN ANESTHETIST					
89 MEDICAL EDUCATION					
89.01 MEDICAL EDUCATION - ALLIED HEA					
89.02 MEDICAL EDUCATION - ALL OTHER					

TITLE XVIII PART A

SNF

PPS

PART I - ALL PROVIDER COMPONENTS

1

INPATIENT DAYS

1	INPATIENT DAYS (INCLUDING PRIVATE ROOM AND SWING BED DAYS, EXCLUDING NEWBORN)	4,623
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM, EXCLUDING SWING-BED AND NEWBORN DAYS)	4,623
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	4,623
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
7	TOTAL SWING-BED NF TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
8	TOTAL SWING-BED NF TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
9	TOTAL INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	3,402
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
11	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V & XIX ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLE V & XIX ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED DAYS)	
15	TOTAL NURSERY DAYS (TITLE V OR XIX ONLY)	
16	NURSERY DAYS (TITLE V OR XIX ONLY)	

SWING-BED ADJUSTMENT

17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	180.51
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST	2,171,531
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
23	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
24	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
26	TOTAL SWING-BED COST (SEE INSTRUCTIONS)	2,171,531
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	999,815
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	999,815
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO	2.171933
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE	
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE	216.27
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL	
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL	
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT	
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL	2,171,531

TITLE XVIII PART A

SNF

PPS

PART III - SKILLED NURSING FACILITY, NURSING FACILITY & ICF/MR ONLY

		1
66	SKILLED NURSING FACILITY/OTHER NURSING FACILITY/ICF/MR ROUTINE SERVICE COST	2,171,531
67	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM	469.72
68	PROGRAM ROUTINE SERVICE COST	1,597,987
69	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO PROGRAM	
70	TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COSTS	1,597,987
71	CAPITAL-RELATED COST ALLOCATED TO INPATIENT ROUTINE SERVICE COSTS	120,754
72	PER DIEM CAPITAL-RELATED COSTS	26.12
73	PROGRAM CAPITAL-RELATED COSTS	88,860
74	INPATIENT ROUTINE SERVICE COST	1,509,127
75	AGGREGATE CHARGES TO BENEFICIARIES FOR EXCESS COSTS	
76	TOTAL PROGRAM ROUTINE SERVICE COSTS FOR COMPARISON TO THE COST LIMITATION	1,509,127
77	INPATIENT ROUTINE SERVICE COST PER DIEM LIMITATION	
78	INPATIENT ROUTINE SERVICE COST LIMITATION	1,597,987
79	REASONABLE INPATIENT ROUTINE SERVICE COSTS	668,982
80	PROGRAM INPATIENT ANCILLARY SERVICES	
81	UTILIZATION REVIEW - PHYSICIAN COMPENSATION	
82	TOTAL PROGRAM INPATIENT OPERATING COSTS	2,266,969

PART IV - COMPUTATION OF OBSERVATION BED COST

83	TOTAL OBSERVATION BED DAYS
84	ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM
85	OBSERVATION BED COST

COMPUTATION OF OBSERVATION BED PASS THROUGH COST

	COST	ROUTINE COST	COLUMN 1 DIVIDED BY COLUMN 2	TOTAL OBSERVATION BED COST	OBSERVATION BED PASS THROUGH COST
	1	2	3	4	5
86	OLD CAPITAL-RELATED COST				
87	NEW CAPITAL-RELATED COST				
88	NON PHYSICIAN ANESTHETIST				
89	MEDICAL EDUCATION				
89.01	MEDICAL EDUCATION - ALLIED HEA				
89.02	MEDICAL EDUCATION - ALL OTHER				

TITLE XVIII, PART A		HOSPITAL		OTHER	
WKST A	COST CENTER DESCRIPTION	RATIO COST	INPATIENT	INPATIENT	
LINE NO.		TO CHARGES	CHARGES	COST	
		1	2	3	
25	INPAT ROUTINE SRVC CNTRS ADULTS & PEDIATRICS		4,465,319		
37	ANCILLARY SRVC COST CNTRS	.659898	98,800	65,198	
40	OPERATING ROOM	1.008044	6,183	6,233	
41	ANESTHESIOLOGY	.200812	1,652,648	331,872	
44	RADIOLOGY-DIAGNOSTIC	.338760	1,566,291	530,597	
49	LABORATORY	.453347	95,522	43,305	
50	RESPIRATORY THERAPY	.569687	217,902	124,136	
50	PHYSICAL THERAPY	.268453			
50	01 PHYSICAL THERAPY - SNF	.412151	49,749	20,504	
52	SPEECH PATHOLOGY	.221470	308,644	68,355	
53	ELECTROCARDIOLOGY				
54	ELECTROENCEPHALOGRAPHY	.157808	1,342,162	211,804	
55	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.033791	8,998	9,302	
55	01 IMPLANTABLE DEVICES	.656764	891,919	585,780	
56	DRUGS CHARGED TO PATIENTS				
	OUTPAT SERVICE COST CNTRS				
61	EMERGENCY	.616778	4,674	2,883	
62	OBSERVATION BEDS (NON-DISTINCT PART)	1.112363	31	34	
	OTHER REIMBURS COST CNTRS				
101	TOTAL		6,243,523	2,000,003	
102	LESS PBP CLINIC LABORATORY SERVICES -				
	PROGRAM ONLY CHARGES				
103	NET CHARGES		6,243,523		

TITLE XVIII, PART A	SKILLED NURSING FACILITY	PPS
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WKST A LINE NO.	COST CENTER DESCRIPTION	RATIO COST TO CHARGES 1	INPATIENT CHARGES 2	INPATIENT COST 3
25	INPAT ROUTINE SRVC CNTRS ADULTS & PEDIATRICS			
	ANCILLARY SRVC COST CNTRS			
37	OPERATING ROOM	.659898	4,849	3,200
40	ANESTHESIOLOGY	1.008044	280	282
41	RADIOLOGY-DIAGNOSTIC	.200812	117,683	23,632
44	LABORATORY	.338760	197,674	66,964
49	RESPIRATORY THERAPY	.453347	11,221	5,087
50	PHYSICAL THERAPY	.569687		
50	01 PHYSICAL THERAPY - SNF	.268453	1,292,890	347,080
52	SPEECH PATHOLOGY	.412151		
53	ELECTROCARDIOLOGY	.221470	5,409	1,198
54	ELECTROENCEPHALOGRAPHY			
55	MEDICAL SUPPLIES CHARGED TO PATIENTS	.157808	289,385	45,667
55	01 IMPLANTABLE DEVICES	1.033791		
56	DRUGS CHARGED TO PATIENTS	.656764	267,785	175,872
	OUTPAT SERVICE COST CNTRS			
61	EMERGENCY	.616778		
62	OBSERVATION BEDS (NON-DISTINCT PART)	1.112363		
	OTHER REIMBURS COST CNTRS			
101	TOTAL		2,187,176	668,982
102	LESS PBP CLINIC LABORATORY SERVICES - PROGRAM ONLY CHARGES			
103	NET CHARGES		2,187,176	

PART B - MEDICAL AND OTHER HEALTH SERVICES

HOSPITAL

1	MEDICAL AND OTHER SERVICES (SEE INSTRUCTIONS)	5,521,405
1.01	MEDICAL AND OTHER SERVICES RENDERED ON OR AFTER APRIL 1, 2001 (SEE INSTRUCTIONS).	
1.02	PPS PAYMENTS RECEIVED INCLUDING OUTLIERS.	
1.03	ENTER THE HOSPITAL SPECIFIC PAYMENT TO COST RATIO.	
1.04	LINE 1.01 TIMES LINE 1.03.	
1.05	LINE 1.02 DIVIDED BY LINE 1.04.	
1.06	TRANSITIONAL CORRIDOR PAYMENT (SEE INSTRUCTIONS)	
1.07	ENTER THE AMOUNT FROM WORKSHEET D, PART IV, (COLS 9, 9.01, 9.02) LINE 101.	
2	INTERNS AND RESIDENTS	
3	ORGAN ACQUISITIONS	
4	COST OF TEACHING PHYSICIANS	
5	TOTAL COST (SEE INSTRUCTIONS)	5,521,405

COMPUTATION OF LESSER OF COST OR CHARGES

6	REASONABLE CHARGES	
7	ANCILLARY SERVICE CHARGES	
8	INTERNS AND RESIDENTS SERVICE CHARGES	
9	ORGAN ACQUISITION CHARGES	
10	CHARGES OF PROFESSIONAL SERVICES OF TEACHING PHYSICIANS.	
11	TOTAL REASONABLE CHARGES	
12	CUSTOMARY CHARGES	
13	AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS	
14	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(e).	
15	RATIO OF LINE 11 TO LINE 12	
16	TOTAL CUSTOMARY CHARGES (SEE INSTRUCTIONS)	
17	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST	
18	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES	
19	LESSER OF COST OR CHARGES (FOR CAH SEE INSTRUC)	5,576,619
20	TOTAL PROSPECTIVE PAYMENT (SUM OF LINES 1.02, 1.06 AND 1.07)	

21	COMPUTATION OF REIMBURSEMENT SETTLEMENT	
22	CAH DEDUCTIBLES	75,863
23	CAH ACTUAL BILLED COINSURANCE	2,576,056
24	LINE 17.01 (SEE INSTRUCTIONS)	
25	SUBTOTAL (SEE INSTRUCTIONS)	2,924,700
26	SUM OF AMOUNTS FROM WORKSHEET E PARTS C, D & E (SEE INSTR.)	
27	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS	
28	ESRD DIRECT MEDICAL EDUCATION COSTS	2,924,700
29	SUBTOTAL	974
30	PRIMARY PAYER PAYMENTS	2,923,726
31	SUBTOTAL	

32	REIMBURSABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)	
33	COMPOSITE RATE ESRD	514,601
34	BAD DEBTS (SEE INSTRUCTIONS)	514,601
35	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	435,542
36	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES	3,438,327
37	SUBTOTAL	
38	RECOVERY OF EXCESS DEPRECIATION RESULTING FROM PROVIDER TERMINATION OR A DECREASE IN PROGRAM UTILIZATION.	
39	OTHER ADJUSTMENTS (SPECIFY)	
40	OTHER ADJUSTMENTS (MSP-LCC RECONCILIATION AMOUNT)	
41	AMOUNTS APPLICABLE TO PRIOR COST REPORTING PERIODS RESULTING FROM DISPOSITION OF DEPRECIABLE ASSETS.	
42	SUBTOTAL	3,438,327
43	SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)	3,298,797
44	INTERIM PAYMENTS	
45	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)	139,530
46	BALANCE DUE PROVIDER/PROGRAM	83,473
47	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2	

48	TO BE COMPLETED BY CONTRACTOR	
49	ORIGINAL OUTLIER AMOUNT (SEE INSTRUCTIONS)	
50	OUTLIER RECONCILIATION AMOUNT (SEE INSTRUCTIONS)	
51	THE RATE USED TO CALCULATE THE TIME VALUE OF MONEY	
52	TIME VALUE OF MONEY (SEE INSTRUCTIONS)	
53	TOTAL (SUM OF LINES 51 AND 53)	

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

TITLE XVIII HOSPITAL

DESCRIPTION	INPATIENT-PART A		P A R T B	
	MM/DD/YYYY	AMOUNT	MM/DD/YYYY	AMOUNT
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER	1	2	3	4
2 INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS, EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY, FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE "NONE" OR ENTER A ZERO.		4,580,460 NONE		3,394,798 NONE
3 LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE "NONE" OR ENTER A ZERO. (1)				
ADJUSTMENTS TO PROVIDER	.01	4/16/2010		56,006
ADJUSTMENTS TO PROVIDER	.02			
ADJUSTMENTS TO PROVIDER	.03			
ADJUSTMENTS TO PROVIDER	.04			
ADJUSTMENTS TO PROVIDER	.05			
ADJUSTMENTS TO PROGRAM	.50		4/16/2010	96,001
ADJUSTMENTS TO PROGRAM	.51			
ADJUSTMENTS TO PROGRAM	.52			
ADJUSTMENTS TO PROGRAM	.53			
ADJUSTMENTS TO PROGRAM	.54			
SUBTOTAL	.99	56,006		-96,001
4 TOTAL INTERIM PAYMENTS		4,636,466		3,298,797
TO BE COMPLETED BY INTERMEDIARY				
5 LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE "NONE" OR ENTER A ZERO. (1)				
TENTATIVE TO PROVIDER	.01			
TENTATIVE TO PROVIDER	.02			
TENTATIVE TO PROVIDER	.03			
TENTATIVE TO PROGRAM	.50			
TENTATIVE TO PROGRAM	.51			
TENTATIVE TO PROGRAM	.52			
SUBTOTAL	.99	NONE		NONE
6 DETERMINED NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON COST REPORT (1)		533,568		139,530
7 TOTAL MEDICARE PROGRAM LIABILITY		5,170,034		3,438,327

NAME OF INTERMEDIARY:
INTERMEDIARY NO:

SIGNATURE OF AUTHORIZED PERSON: _____

DATE: ____/____/____

(1) ON LINES 3, 5 AND 6, WHERE AN AMOUNT IS DUE PROVIDER TO PROGRAM, SHOW THE AMOUNT AND DATE ON WHICH THE PROVIDER AGREES TO THE AMOUNT OF REPAYMENT, EVEN THOUGH TOTAL REPAYMENT IS NOT ACCOMPLISHED UNTIL A LATER DATE.

TITLE XVIII SNF

DESCRIPTION	INPATIENT-PART A		P A R T B	
	MM/DD/YYYY	AMOUNT	MM/DD/YYYY	AMOUNT
	1	2	3	4
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER		1,192,805		
2 INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS, EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY, FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE "NONE" OR ENTER A ZERO.		NONE		NONE
3 LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE "NONE" OR ENTER A ZERO. (1)				
ADJUSTMENTS TO PROVIDER		.01		
ADJUSTMENTS TO PROVIDER		.02		
ADJUSTMENTS TO PROVIDER		.03		
ADJUSTMENTS TO PROVIDER		.04		
ADJUSTMENTS TO PROVIDER		.05		
ADJUSTMENTS TO PROGRAM		.50		
ADJUSTMENTS TO PROGRAM		.51		
ADJUSTMENTS TO PROGRAM		.52		
ADJUSTMENTS TO PROGRAM		.53		
ADJUSTMENTS TO PROGRAM		.54		
SUBTOTAL		.99		
4 TOTAL INTERIM PAYMENTS		NONE		NONE
		1,192,805		
TO BE COMPLETED BY INTERMEDIARY				
5 LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE "NONE" OR ENTER A ZERO. (1)				
TENTATIVE TO PROVIDER		.01		
TENTATIVE TO PROVIDER		.02		
TENTATIVE TO PROVIDER		.03		
TENTATIVE TO PROGRAM		.50		
TENTATIVE TO PROGRAM		.51		
TENTATIVE TO PROGRAM		.52		
SUBTOTAL		.99		
6 DETERMINED NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON COST REPORT (1)		NONE		NONE
SETTLEMENT TO PROVIDER		.01		
SETTLEMENT TO PROGRAM		.02		
7 TOTAL MEDICARE PROGRAM LIABILITY		1,192,805		

NAME OF INTERMEDIARY:
INTERMEDIARY NO:

SIGNATURE OF AUTHORIZED PERSON: _____

DATE: ____/____/____

(1) ON LINES 3, 5 AND 6, WHERE AN AMOUNT IS DUE PROVIDER TO PROGRAM, SHOW THE AMOUNT AND DATE ON WHICH THE PROVIDER AGREES TO THE AMOUNT OF REPAYMENT, EVEN THOUGH TOTAL REPAYMENT IS NOT ACCOMPLISHED UNTIL A LATER DATE.

(1) ON LINES 3, 5 AND 6, WHERE AN AMOUNT IS DUE PROVIDER TO PROGRAM, SHOW THE AMOUNT AND DATE ON WHICH THE PROVIDER AGREES TO THE AMOUNT OF REPAYMENT, EVEN THOUGH TOTAL REPAYMENT IS NOT ACCOMPLISHED UNTIL A LATER DATE.

TITLE XVIII

SWING BED SNF

COMPUTATION OF NET COST OF COVERED SERVICES		PART A 1	PART B 2
1	INPATIENT ROUTINE SERVICES - SWING BED-SNF (SEE INSTR)	301,806	
2	INPATIENT ROUTINE SERVICES - SWING BED-NF (SEE INSTR)		
3	ANCILLARY SERVICES (SEE INSTRUCTIONS)	96,590	
4	PER DIEM COST FOR INTERNS AND RESIDENTS NOT IN APPROVED TEACHING PROGRAM (SEE INSTRUCTIONS)		
5	PROGRAM DAYS	326	
6	INTERNS AND RESIDENTS NOT IN APPROVED TEACHING PROGRAM (SEE INSTRUCTIONS)		
7	UTILIZATION REVIEW - PHYSICIAN COMPENSATION - SNF OPTIONAL METHOD ONLY		
8	SUBTOTAL	398,396	
9	PRIMARY PAYER PAYMENTS (SEE INSTRUCTIONS)		
10	SUBTOTAL	398,396	
11	DEDUCTIBLES BILLED TO PROGRAM PATIENTS (EXCLUDE AMOUNTS APPLICABLE TO PHYSICIAN PROFESSIONAL SERVICES)		
12	SUBTOTAL	398,396	
13	COINSURANCE BILLED TO PROGRAM PATIENTS (FROM PROVIDER RECORDS)(EXCLUDE COINSURANCE FOR PHYSICIAN PROFESSIONAL SERVICES)	5,279	
14	80% OF PART B COSTS		
15	SUBTOTAL	393,117	
16	OTHER ADJUSTMENTS (SPECIFY)		
17	REIMBURSABLE BAD DEBTS		
17.01	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)		
18	TOTAL	393,117	
19	SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)		
20	INTERIM PAYMENTS	338,718	
20.01	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)		
21	BALANCE DUE PROVIDER/PROGRAM	54,399	
22	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2.	5,964	

PART II - MEDICARE PART A SERVICES - COST REIMBURSEMENT HOSPITAL

1	INPATIENT SERVICES	5,716,897
1.01	NURSING AND ALLIED HEALTH MANAGED CARE PAYMENT	
2	ORGAN ACQUISITION	
3	COST OF TEACHING PHYSICIANS	
4	SUBTOTAL	5,716,897
5	PRIMARY PAYER PAYMENTS	1,106
6	TOTAL COST. FOR CAH (SEE INSTRUCTIONS)	5,772,949
COMPUTATION OF LESSER OF COST OR CHARGES		
REASONABLE CHARGES		
7	ROUTINE SERVICE CHARGES	
8	ANCILLARY SERVICE CHARGES	
9	ORGAN ACQUISITION CHARGES, NET OF REVENUE	
10	TEACHING PHYSICIANS	
11	TOTAL REASONABLE CHARGES	
CUSTOMARY CHARGES		
12	AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS	
13	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(e)	
14	RATIO OF LINE 12 TO LINE 13 (NOT TO EXCEED 1.000000)	
15	TOTAL CUSTOMARY CHARGES (SEE INSTRUCTIONS)	
16	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST	
17	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES	
COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS	
19	COST OF COVERED SERVICES	5,772,949
20	DEDUCTIBLES (EXCLUDE PROFESSIONAL COMPONENT)	729,352
21	EXCESS REASONABLE COST	
22	SUBTOTAL	5,043,597
23	COINSURANCE	2,467
24	SUBTOTAL	5,041,130
25	REIMBURSABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES (SEE INSTRUCTIONS))	128,904
25.01	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	128,904
25.02	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES	113,504
26	SUBTOTAL	5,170,034
27	RECOVERY OF EXCESS DEPRECIATION RESULTING FROM PROVIDER TERMINATION OR A DECREASE IN PROGRAM UTILIZATION	
28	OTHER ADJUSTMENTS (SPECIFY)	
29	AMOUNTS APPLICABLE TO PRIOR COST REPORTING PERIODS RESULTING FROM DISPOSITION OF DEPRECIABLE ASSETS	
30	SUBTOTAL	5,170,034
31	SEQUESTRATION ADJUSTMENT	
32	INTERIM PAYMENTS	4,636,466
32.01	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)	
33	BALANCE DUE PROVIDER/PROGRAM	533,568
34	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS)	86,427
IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2.		

PART III - TITLE V OR TITLE XIX SERVICES OR TITLE XVIII SNF PPS ONLY

	TITLE XVIII	SNF	PPS TITLE V OR TITLE XIX 1	TITLE XVIII SNF PPS 2
1	COMPUTATION OF NET COST OF COVERED SERVICE			
2	INPATIENT HOSPITAL/SNF/NF SERVICES			
3	MEDICAL AND OTHER SERVICES			
4	INTERNS AND RESIDENTS (SEE INSTRUCTIONS)			
5	ORGAN ACQUISITION (CERT TRANSPLANT CENTERS ONLY)			
6	COST OF TEACHING PHYSICIANS (SEE INSTRUCTIONS)			
7	SUBTOTAL			
8	INPATIENT PRIMARY PAYER PAYMENTS			
9	OUTPATIENT PRIMARY PAYER PAYMENTS			
	SUBTOTAL			
	COMPUTATION OF LESSER OF COST OR CHARGES			
	REASONABLE CHARGES			
10	ROUTINE SERVICE CHARGES			
11	ANCILLARY SERVICE CHARGES			
12	INTERNS AND RESIDENTS SERVICE CHARGES			
13	ORGAN ACQUISITION CHARGES, NET OF REVENUE			
14	TEACHING PHYSICIANS			
15	INCENTIVE FROM TARGET AMOUNT COMPUTATION			
16	TOTAL REASONABLE CHARGES			
	CUSTOMARY CHARGES			
17	AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR			
18	PAYMENT FOR SERVICES ON A CHARGE BASIS			
19	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE			
20	FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT			
21	BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(e)			
22	RATIO OF LINE 17 TO LINE 18			
23	TOTAL CUSTOMARY CHARGES (SEE INSTRUCTIONS)			
24	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST			
25	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES			
26	COST OF COVERED SERVICES			
27	PROSPECTIVE PAYMENT AMOUNT			
28	OTHER THAN OUTLIER PAYMENTS			1,354,162
29	OUTLIER PAYMENTS			
30	PROGRAM CAPITAL PAYMENTS			
31	CAPITAL EXCEPTION PAYMENTS (SEE INSTRUCTIONS)			
32	ROUTINE SERVICE OTHER PASS THROUGH COSTS			
33	ANCILLARY SERVICE OTHER PASS THROUGH COSTS			
34	SUBTOTAL			1,354,162
35	CUSTOMARY CHARGES (TITLE XIX PPS COVERED SERVICES ONLY)			
36	TITLES V OR XIX PPS, LESSER OF LNS 30 OR 31; NON PPS & TITLE			1,354,162
37	XVIII ENTER AMOUNT FROM LINE 30			
38	DEDUCTIBLES (EXCLUDE PROFESSIONAL COMPONENT)			
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
39	EXCESS OF REASONABLE COST			
40	SUBTOTAL			1,354,162
41	COINSURANCE			161,357
42	SUM OF AMOUNTS FROM WKST. E, PARTS C, D & E, LN 19			
43	REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)			
44	ADJUSTED REIMBURSABLE BAD DEBTS FOR PERIODS ENDING			
45	BEFORE 10/01/05 (SEE INSTRUCTIONS)			
46	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES			
47	ADJUSTED REIMBURSABLE BAD DEBTS FOR PERIODS BEGINNING			
48	ON OR AFTER 10/01/05 (SEE INSTRUCTIONS)			
49	UTILIZATION REVIEW			
50	SUBTOTAL (SEE INSTRUCTIONS)			1,192,805
51	INPATIENT ROUTINE SERVICE COST			
52	MEDICARE INPATIENT ROUTINE CHARGES			
53	AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR			
54	PAYMENT FOR SERVICES ON A CHARGE BASIS			
55	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE			
56	FOR PAYMENT OF PART A SERVICES			
57	RATIO OF LINE 43 TO 44			
58	TOTAL CUSTOMARY CHARGES			
59	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST			
60	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES			
61	RECOVERY OF EXCESS DEPRECIATION RESULTING FROM PROVIDER			
62	TERMINATION OR A DECREASE IN PROGRAM UTILIZATION			
63	OTHER ADJUSTMENTS (SPECIFY)			
64	AMOUNTS APPLICABLE TO PRIOR COST REPORTING PERIODS			
65	RESULTING FROM DISPOSITION OF DEPRECIABLE ASSETS			
66	SUBTOTAL			1,192,805
67	INDIRECT MEDICAL EDUCATION ADJUSTMENT (PPS ONLY)			
68	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS			
69	TOTAL AMOUNT PAYABLE TO THE PROVIDER			1,192,805
70	SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)			
71	INTERIM PAYMENTS			1,192,805
72	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)			
73	BALANCE DUE PROVIDER/PROGRAM			
74	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS)			

PART III - TITLE V OR TITLE XIX SERVICES OR TITLE XVIII SNF PPS ONLY

IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2.

	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
ASSETS	1	2	3	4
CURRENT ASSETS				
1 CASH ON HAND AND IN BANKS	6,703,448			
2 TEMPORARY INVESTMENTS	4,020,705			
3 NOTES RECEIVABLE				
4 ACCOUNTS RECEIVABLE	4,999,656			
5 OTHER RECEIVABLES	498,659			
6 LESS: ALLOWANCE FOR UNCOLLECTIBLE NOTES & ACCOUNTS RECEIVABLE	-1,039,443			
7 INVENTORY	579,173			
8 PREPAID EXPENSES	200,289			
9 OTHER CURRENT ASSETS	6,529,151			
10 DUE FROM OTHER FUNDS	15,391			
11 TOTAL CURRENT ASSETS	22,507,029			
FIXED ASSETS				
12 LAND	642,244			
12.01 LAND IMPROVEMENTS	657,293			
13.01 LESS ACCUMULATED DEPRECIATION	-637,966			
14 BUILDINGS	18,402,348			
14.01 LESS ACCUMULATED DEPRECIATION	-3,663,634			
15 LEASEHOLD IMPROVEMENTS				
15.01 LESS ACCUMULATED DEPRECIATION				
16 FIXED EQUIPMENT				
16.01 LESS ACCUMULATED DEPRECIATION				
17 AUTOMOBILES AND TRUCKS				
17.01 LESS ACCUMULATED DEPRECIATION				
18 MAJOR MOVABLE EQUIPMENT	19,886,207			
18.01 LESS ACCUMULATED DEPRECIATION	-15,657,867			
19 MINOR EQUIPMENT DEPRECIABLE				
19.01 LESS ACCUMULATED DEPRECIATION				
20 MINOR EQUIPMENT-NONDEPRECIABLE				
21 TOTAL FIXED ASSETS	19,628,625			
OTHER ASSETS				
22 INVESTMENTS	491,734			
23 DEPOSITS ON LEASES				
24 DUE FROM OWNERS/OFFICERS				
25 OTHER ASSETS				
26 TOTAL OTHER ASSETS	491,734			
27 TOTAL ASSETS	42,627,388			

BALANCE SHEET

	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
LIABILITIES AND FUND BALANCE	1	2	3	4
CURRENT LIABILITIES				
28 ACCOUNTS PAYABLE	1,724,264			
29 SALARIES, WAGES & FEES PAYABLE	1,756,325			
30 PAYROLL TAXES PAYABLE				
31 NOTES AND LOANS PAYABLE (SHORT TERM)	114,483			
32 DEFERRED INCOME				
33 ACCELERATED PAYMENTS				
34 DUE TO OTHER FUNDS	10,297			
35 OTHER CURRENT LIABILITIES	1,217,053			
36 TOTAL CURRENT LIABILITIES	4,822,422			
LONG TERM LIABILITIES				
37 MORTGAGE PAYABLE				
38 NOTES PAYABLE	18,355,517			
39 UNSECURED LOANS				
40.01 LOANS PRIOR TO 7/1/66				
40.02 ON OR AFTER 7/1/66				
41 OTHER LONG TERM LIABILITIES	446,000			
42 TOTAL LONG-TERM LIABILITIES	18,801,517			
43 TOTAL LIABILITIES	23,623,939			
CAPITAL ACCOUNTS				
44 GENERAL FUND BALANCE	19,003,449			
45 SPECIFIC PURPOSE FUND				
46 DONOR CREATED- ENDOWMENT FUND BALANCE- RESTRICTED				
47 DONOR CREATED- ENDOWMENT FUND BALANCE- UNRESTRICT				
48 GOVERNING BODY CREATED- ENDOWMENT FUND BALANCE				
49 PLANT FUND BALANCE-INVESTED IN PLANT				
50 PLANT FUND BALANCE- RESERVE FOR PLANT IMPROVEMENT, REPLACEMENT AND EXPANSION				
51 TOTAL FUND BALANCES	19,003,449			
52 TOTAL LIABILITIES AND FUND BALANCES	42,627,388			

STATEMENT OF CHANGES IN FUND BALANCES

I	PROVIDER NO:	I	PERIOD:	I	PREPARED	2/17/2011
I	14-1339	I	FROM 10/ 1/2009	I	WORKSHEET	G-1
I		I	TO 9/30/2010	I		

	GENERAL FUND	SPECIFIC PURPOSE FUND
	1	2
	3	4
1 FUND BALANCE AT BEGINNING		
OF PERIOD		17,192,825
2 NET INCOME (LOSS)		1,810,624
3 TOTAL		19,003,449
ADDITIONS (CREDIT ADJUSTMENTS) (SPECIFY)		
ADDITIONS (CREDIT ADJUSTM		
4		
5		
6		
7		
8		
9		
10 TOTAL ADDITIONS		
11 SUBTOTAL		19,003,449
DEDUCTIONS (DEBIT ADJUSTMENTS) (SPECIFY)		
DEDUCTIONS (DEBIT ADJUSTM		
12		
13		
14		
15		
16		
17		
18 TOTAL DEDUCTIONS		
19 FUND BALANCE AT END OF		19,003,449
PERIOD PER BALANCE SHEET		

	ENDOWMENT FUND	PLANT FUND
	5	6
	7	8
1 FUND BALANCE AT BEGINNING		
OF PERIOD		
2 NET INCOME (LOSS)		
3 TOTAL		
ADDITIONS (CREDIT ADJUSTMENTS) (SPECIFY)		
ADDITIONS (CREDIT ADJUSTM		
4		
5		
6		
7		
8		
9		
10 TOTAL ADDITIONS		
11 SUBTOTAL		
DEDUCTIONS (DEBIT ADJUSTMENTS) (SPECIFY)		
DEDUCTIONS (DEBIT ADJUSTM		
12		
13		
14		
15		
16		
17		
18 TOTAL DEDUCTIONS		
19 FUND BALANCE AT END OF		
PERIOD PER BALANCE SHEET		

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

I PROVIDER NO:
 I 14-1339
 I

I PERIOD:

I FROM 10/ 1/2009
I TO 9/30/2010

I PREPARED 2/17/2011
I WORKSHEET G-2
I PARTS I & II

PART I - PATIENT REVENUES

REVENUE CENTER		INPATIENT 1	OUTPATIENT 2	TOTAL 3
	GENERAL INPATIENT ROUTINE CARE SERVICES			
1	00 HOSPITAL	5,587,909		5,587,909
4	00 SWING BED - SNF	170,648		170,648
5	00 SWING BED - NF	4,711		4,711
6	00 SKILLED NURSING FACILITY	999,815		999,815
9	00 TOTAL GENERAL INPATIENT ROUTINE CARE	6,763,083		6,763,083
	INTENSIVE CARE TYPE INPATIENT HOSPITAL SVCS			
15	00 TOTAL INTENSIVE CARE TYPE INPAT HOSP			
16	00 TOTAL INPATIENT ROUTINE CARE SERVICE	6,763,083		6,763,083
17	00 ANCILLARY SERVICES	11,200,545		11,200,545
18	00 OUTPATIENT SERVICES		39,569,069	39,569,069
24	00 PRO FEES	321,085	5,562,781	5,883,866
25	00 TOTAL PATIENT REVENUES	18,284,713	45,131,850	63,416,563

PART II-OPERATING EXPENSES

26	00	OPERATING EXPENSES		
		ADD (SPECIFY)		27,471,183
27	00	BAD DEBT EXPENSE		
28	00		1,794,988	
29	00			
30	00			
31	00			
32	00			
33	00	TOTAL ADDITIONS		
		DEDUCT (SPECIFY)		1,794,988
34	00	DEDUCT (SPECIFY)		
35	00			
36	00			
37	00			
38	00			
39	00	TOTAL DEDUCTIONS		
40	00	TOTAL OPERATING EXPENSES		29,266,171

STATEMENT OF REVENUES AND EXPENSES

I
I
IPROVIDER NO:
14-1339I PERIOD:
I FROM 10/ 1/2009
I TO 9/30/2010I PREPARED 2/17/2011
I WORKSHEET G-3

DESCRIPTION

1	TOTAL PATIENT REVENUES	63,416,563
2	LESS: ALLOWANCES AND DISCOUNTS ON PATIENT'S ACCTS	34,363,713
3	NET PATIENT REVENUES	29,052,850
4	LESS: TOTAL OPERATING EXPENSES	29,266,171
5	NET INCOME FROM SERVICE TO PATIENTS	-213,321
	OTHER INCOME	
6	CONTRIBUTIONS, DONATIONS, BEQUESTS, ETC.	21,541
7	INCOME FROM INVESTMENTS	88,957
8	REVENUE FROM TELEPHONE AND TELEGRAPH SERVICE	
9	REVENUE FROM TELEVISION AND RADIO SERVICE	
10	PURCHASE DISCOUNTS	21,725
11	REBATES AND REFUNDS OF EXPENSES	
12	PARKING LOT RECEIPTS	
13	REVENUE FROM LAUNDRY AND LINEN SERVICE	
14	REVENUE FROM MEALS SOLD TO EMPLOYEES AND GUESTS	172,272
15	REVENUE FROM RENTAL OF LIVING QUARTERS	
16	REVENUE FROM SALE OF MEDICAL & SURGICAL SUPPLIES TO OTHER THAN PATIENTS	
17	REVENUE FROM SALE OF DRUGS TO OTHR THAN PATIENTS	
18	REVENUE FROM SALE OF MEDICAL RECORDS & ABSTRACTS	15,184
19	TUITION (FEES, SALE OF TEXTBOOKS, UNIFORMS, ETC)	
20	REVENUE FROM GIFTS, FLOWER, COFFEE SHOP & CANTEEN	
21	RENTAL OF VENDING MACHINES	
22	RENTAL OF HOSPITAL SPACE	
23	GOVERNMENTAL APPROPRIATIONS	
24	HOSPITAL ACCESS IMPROVEMENT	1,592,211
24.01	SALE OF REFUSE AND JUNK	660
24.02	MISCELLANEOUS INCOME	2,568
24.03	GAIN ON DISPOSAL OF ASSETS	59,794
24.04	GAIN ON DEFERRED COMPENSATION	49,033
25	TOTAL OTHER INCOME	2,023,945
26	TOTAL	1,810,624
	OTHER EXPENSES	
27	OTHER EXPENSES (SPECIFY)	
28		
29		
30	TOTAL OTHER EXPENSES	
31	NET INCOME (OR LOSS) FOR THE PERIOD	1,810,624